California Department of Mental Health
BH-EHR Requirements Survey
Instructions

Steps	Instructions
1	Rename this spreadsheet by selecting **File**, then **Save As**, then **appending "for " and your company name to the end of this filename** and selecting **Save**. The new file name should be: CA BH-EHR Functional Requirements Survey for <your company name>.xls
2	Complete the "Company Info" Tab.
3	Please respond to all of the requirements in all 6 of the Functional Categories: **Infrastructure, Practice Management, Clinical Data, Computerized Provider Order Entry (CPOE), Electronic Health Record (EHR), and Personal Health Record (PHR).** Descriptions of the available response are provided below. Descriptions of the Functional Requirement Categories are provided on the **Descriptions** tab. For each requirement enter a 1 under the response that best describes your solution's ability to meet that requirement. Respond to every requirement even if your solution does not address a particular functional category. A response of "Not Addressed" has no negative connotation when the solution is not purported to provide that category of functionality. Please provide **only one response per requirement**. Multiple responses will be regarded as invalid. Use the **Summary** tab to see whether any functional category has any missing or invalid responses.

Responses	Response Descriptions
Existing	The vendor's solution meets the functional requirement as an existing component of its base product without any effort over and above code table configuration. This response indicates that no programming customization is required to meet the requirement.
Planned	The vendor's solution does not presently meet the functional requirement, but an upgrade to the base product that will meet this requirement is planned within the next 12 months. This response indicates that no programming customization will be required to meet the requirement.
Modification	The vendor's solution does not meet the functional requirement, but will meet the functional requirement with a programming modification to the base product.
Custom Development	The vendor's solution does not meet the functional requirement with any level of modification to the existing code base. The vendor will meet this functional requirement by developing custom software.
3rd Party	The vendor's solution does not meet the functional requirement with any level of modification or customization, but will meet the functional requirement by integrating third party solution(s). Identify the third-party vendor(s) and product(s) in the Comments.
Not Addressed	The vendor's solution does not and will not address this functional requirement.

California Department of Mental Health
BH-EHR Requirements Survey
Company Information

Please provide the following information about your organization.	
Company Name	
Company Address	
Company Web Site	
Product Name(s)	
Product Description(s)	
Primary Contact Name	
Primary Contact Phone	
Primary Contact email	
Date of Response	

CA Department of Mental Health
BH-EHR Requirements Survey
Infrastructure Requirements

Infrastructure

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-35	35.001	The system shall be able to audit the date / time and user of each instance when a client's health information is printed by the system.	Does not include screen print and other functions that are external to the programmed functionality of the EHR system.							
F-35	35.002	The system shall provide a means to document a client's dispute with their health information currently in the system.	Clients review of their health information may be through on-screen viewing or by printing of their health information. This requirement does not require the client shall document their dispute directly into the system. Methods to document their dispute include direct text entry, scanned copying of client comments, or any other authorized method.							
F-35	35.003	The system shall be able to identify all users who have accessed an individual's health information over a given time period, including date and time of access.	Specific items / sections of information accessed shall be identified, with appropriate audit trail.							
F-35	35.004	The system shall be able to identify certain information as confidential and only make that accessible by appropriately authorized users.	This may be implemented by having a "confidential" section of the client's health information.							
F-35	35.005	The system shall be able to prevent specified user(s) from accessing some or all of a designated client's health information.	An example would be preventing access to a VIP or staff member's health information. When access is restricted, the system shall provide a means for appropriately authorized users to "break the glass" for emergency situations. Such overrides shall be audited.							

CA Department of Mental Health
BH-EHR Requirements Survey
Infrastructure Requirements

Infrastructure

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-36	36.001	The system shall be able to retain and retrieve client health information until purged, deleted, archived or otherwise deliberately removed.								
F-36	36.002	The system shall provide a method for archiving client health information, and all supporting electronic files (including application software files).	Archiving is used to mean information stored in a retrievable fashion without defining where or how it is stored.							
F-36	36.003	The system shall be able to retrieve information that has been archived.	Retrieval does not imply restoration to current version of the software.							
F-36	36.005	The system shall be able to retain imported client health information, as originally received (unaltered, inclusive of the method in which they were received.	Implies retention for the legally prescribed time frames.							
F-36	36.006	The system shall be able to retrieve information in a manner conducive to recreating the context in which the information was obtained.								
F-36	36.007	The system shall be able to store and retrieve all the elements included in a legal health (medical) record.								
F-36	36.008	The system shall provide for oversight, review and confirmation of record(s) destruction prior to destroying specific EHR data / records.								

CA Department of Mental Health
BH-EHR Requirements Survey
Infrastructure Requirements

Infrastructure

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-36	36.009	The system shall be able to destroy EHR data / records so that all traces are unrecoverable.								
F-37	37.001	The system shall be able to log exported client health information in an auditable form.								
F-37	37.002	The system shall be able to log the receipt of client health information in an auditable form.								
F-37	37.004	The system shall allow administration, over which system components will have audit controls in place and what types of audit trails are utilized.	Examples of audit trails include: tracking record additions, edits, and deletions, record access, etc.							
F-38	38.001	The system shall be able to export client related health information from the system.	Examples of client related health information include: Performance measurements, chronic disease data, etc.							
F-38	38.002	The system shall be able to import client related health information into the system								
F-38	38.003	The system shall allow removal of discrete client identifiers.	De-identification is necessary for research purposes, e.g., to identify patterns of disease. External applications can be used to meet this criterion.							

CA Department of Mental Health
BH-EHR Requirements Survey
Infrastructure Requirements

Infrastructure

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-38	**38.004**	The system shall be able to specify the intended destination of the extracted information.	The user may indicate to whom they are sending results. The lack of control of information once it leaves the practice is acknowledged.							
F-39	**39.001**	The system shall allow multiple users to interact concurrently with the EHR application.								
F-39	**39.002**	The system shall allow concurrent users to simultaneously view the same client health information or EHR related information.	Examples of other EHR related information includes: clinical, administrative, or financial reports / analyses and documentation templates.							
F-39	**39.004**	The system shall provide protection to maintain the integrity of client health information during concurrent access.	Implies protection against simultaneous record update attempts with resultant loss of data							
F-39	**39.005**	The system shall trigger alerts to simultaneous users of each other's presence in the same data record.								
F-43	**43.013**	The system shall support the downloading, uploading and secure connection for mobile workforce and remote users.								
F-43	**43.038**	The system shall be scalable to meet current and future user access and data storage needs.								
F-43	**43.039**	The system shall incorporate a consistent user interface (UI) for manual and imported data entry.	Implies the UI design should be independent of the proposed hardware configuration.							

CA Department of Mental Health
BH-EHR Requirements Survey
Infrastructure Requirements

Infrastructure

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-43	43.040	The system shall support a variety of data input methods.	Examples of data input include: Voice recognition, Voice dictation, Touch screen, Light pen, Mouse, Keyboard, Electronic tablet, Scanning, Audio files, Optical character recognition, electronic receipt of information (e.g., remote data entry, data file or record uploads, Etc.), "Cut and Paste" or "Copy and Paste", Etc. Implies support for compliance with Americans with Disabilities Act (ADA) requirements.							
F-43	43.041	The system shall support remote system monitoring technology.								
F-43	43.042	The system shall incorporate extensive, secure capabilities that link staff from remote locations to the central site.	Staff is general in nature and includes office support and administrative related staff as well as medical service providers.							
F-43	43.048	The system shall support and implement redundancy / fault tolerance for 100% system availability.								
F-43	43.049	The system shall support secure Web-based system access.								
F-43	43.050	The system shall manage both structured and unstructured health record information during manual and electronic, retrieval, update, reporting, and tracking processes.	Management of actions involving complete or partial records is included.							

CA Department of Mental Health
BH-EHR Requirements Survey
Infrastructure Requirements

Infrastructure

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-43	**43.051**	The system shall support efficient linkage of all associations between structured and unstructured health record information.	Includes structured to structured, unstructured to unstructured, and structured to unstructured data associations.							
S-01	**1.001**	The system shall provide support for assigning users role-based system access.	Examples of support include: Assigning access by User identity, User role, User work assignment, Group work assignments, Client's health condition, and Work Context such as time of day or user / client location(s), etc.							
S-01	**1.002**	The system shall provide the ability for authorized system administrators to add / delete users and assign, modify, or delete related system access restrictions or privileges.	Implies users are human beings or software applications.							
S-01	**1.004**	The system shall maintain a history of system users.								
S-01	**1.018**	The system shall provide the ability to define user access to the application's functions.								
S-01	**1.019**	The system shall require user login passwords be changed regularly.								

CA Department of Mental Health
BH-EHR Requirements Survey
Infrastructure Requirements

Infrastructure

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
S-01	**1.020**	The system shall provide timely support for user password updates.	Examples of timely support include: 1) Automatic notifications to users upon successful access to the application that the current password is due to expire. 2) System Administrator sets how many days prior to password expiration a user will receive related notification.							
S-01	**1.022**	The system shall require valid and secure user login passwords structured.								
S-01	**1.023**	The system shall provide the ability to automatically log users out of the system after a period of inactivity.								
S-01	**1.024**	The system shall comply with client confidentiality and privacy.								
S-01	**1.026**	The system shall allow a user to mark a client's specific health information as blinded, prohibiting access to other users.								
S-01	**1.027**	The system shall support access to blinded information to a treating healthcare service provider, when the blinded information is necessary for managing an emergency condition.	Note: This is commonly known as a "break the glass" function. This does not provide permanently increasing access rights for the healthcare service provider.							

CA Department of Mental Health
BH-EHR Requirements Survey
Infrastructure Requirements

Infrastructure

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
S-01	1.028	The "break the glass" function must be capable of requiring the healthcare service provider requesting access to blinded information to document and record the reason(s) for requesting access.								
S-02	2.001	The system shall authenticate the user before any access to Protected Resources (e.g. PHI) is allowed, including when not connected to a network e.g. mobile devices.								
S-02	2.004	The system shall enforce a limit of consecutive invalid access attempts by a user. The system shall protect against further, possibly malicious, user authentication attempts.	Examples of protection against further authentication attempt include: Locking the account / node until released by a System Administrator, locking the account / node for a configurable time period, or delaying the next login prompt according to a flexible delay algorithm.							
S-02	2.005	The system shall provide an administrative function that resets passwords.								
S-02	2.006	The system shall require the user to change the password after their next successful login when their login account has been reset by a System Administrator .								

CA Department of Mental Health
BH-EHR Requirements Survey
Infrastructure Requirements

Infrastructure

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
S-02	2.007	The system shall provide only limited feedback information to the user during login authentication.								
S-02	2.008	The system shall support case-insensitive usernames that contain typeable alpha-numeric characters in support of ISO-646 / ECMA-6 (aka US ASCII).								
S-02	2.009	The system shall allow an authenticated user to change their password consistent with password strength rules.								
S-02	2.010	The system shall support case-sensitive passwords that contain typeable alpha-numeric characters in support of ISO-646 / ECMA-6 (aka US ASCII).								
S-02	2.011	The system shall not store passwords in plain text.								
S-02	2.012	The system shall prevent the reuse of passwords previously used within a specific (configurable) timeframe (i.e., within the last X days, etc. - e.g. "last 180 days"), or shall prevent the reuse of a certain (configurable) number of the most recently used passwords (e.g. "last 5 passwords").								

CA Department of Mental Health
BH-EHR Requirements Survey
Infrastructure Requirements

Infrastructure

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
S-02	**2.015**	The system shall provide the ability to implement Chain of Trust agreements.								
S-02	**2.016**	The system shall support, at a minimum, two-factor authentication in alignment with NIST 800-63 Level 3 Authentication.								
S-02	**2.017**	The system shall not export passwords in plain text.								
S-02	**2.018**	The system shall not display passwords while being entered.								
S-03	**3.001**	The system shall include documentation available to the customer that provides guidelines for configuration and use of the EHR System security controls necessary to support secure and reliable operation of the system, including but not limited to: creation, modification, and deactivation of user accounts, management of roles, reset of passwords, configuration of password constraints, and audit logs.								

CA Department of Mental Health
BH-EHR Requirements Survey
Infrastructure Requirements

Infrastructure

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
S-04	4.001	The system shall support protection of confidentiality of all Protected Health Information (PHI) delivered over the Internet or other known open networks via encryption using triple-DES (3DES) or the Advanced Encryption Standard (AES) and an open protocol such as TLS, SSL, IPSec, XML encryptions, or S/MIME or their successors.								
S-04	4.004	The system shall include the capability to encrypt the data communicated over the network via SSL (HTML over HTTPS) for systems that provide access to PHI through a web browser interface (i.e. HTML over HTTP) .	Note: Web browser interfaces are often used beyond the perimeter of the protected enterprise network							
S-04	4.005	The system shall support protection of integrity of all Protected Health Information (PHI) delivered over the Internet or other known open networks via SHA1 hashing and an open protocol such as TLS, SSL, IPSec, XML digital signature, or S/MIME or their successors.								

CA Department of Mental Health
BH-EHR Requirements Survey
Infrastructure Requirements

Infrastructure

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
S-04	4.006	The system shall support ensuring the authenticity of remote nodes (mutual node authentication) when communicating Protected Health Information (PHI) over the Internet or other known open networks using an open protocol (e.g. TLS, SSL, IPSec, XML sig, S/MIME).								
S-04	4.007	The system, when storing PHI on any physical media intended to be portable / removable (e.g. thumb-drives, CD-ROM, PDA), shall support use of a standards based encrypted format using triple-DES (3DES), and the Advanced Encryption Standard (AES).								
S-04	4.008	The system shall have security measures to project data being transmitted via wireless networks, including data communications with portable devices.								
S-04	4.009	The system shall provide the ability to obfuscate (intentionally make difficult to read) data.								

CA Department of Mental Health
BH-EHR Requirements Survey
Infrastructure Requirements

Infrastructure

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
S-04	4.013	The system shall provide the ability to link data entry by a user to another user per defined "Role Based" relationships.	For example: a student or trainee is not authorized to release data in a client's EHR, but may enter it. The supervisor or trainer must review and release the data. The supervisor or trainer's identifier must be stored with the released data.							
S-04	4.014	The system shall support the storage of any Protected Health Information (PHI) data on any associated mobile device(s) in an encrypted format.	Implies encryption is via triple-DES (3DES), the Advanced Encryption Standard (AES), or their successors. . Examples of mobile devices include: PDAs, smart phones, etc.							
S-04	4.015	The system, prior to a user login, shall display a warning notice (e.g. "The system should only be accessed by authorized users").								
S-04	4.016	The system shall be able to support time synchronization using NTP / SNTP, and use this synchronized time in all security records of time.								
S-04	4.017	The system shall have the ability to format for export recorded time stamps using UTC based on ISO 8601. Example: "1994-11-05T08:15:30-05:00" corresponds to November 5, 1994, 8:15:30 am, US Eastern Standard Time.								

CA Department of Mental Health
BH-EHR Requirements Survey
Infrastructure Requirements

Infrastructure

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
S-05	**5.001**	The system shall support logging to a common audit engine using the schema and transports specified in the Audit Log specification of IHE (Integrated Healthcase Enterprise) , Audit Trails and Node Authentication (ATNA) Profile.	Examples of audit trails include: Versions of installed software, code sets, knowledge bases, backup and recovery resolutions, system date / time changes, archived data storage or restoration, and user EHR System access (internal or external).							
S-05	**5.004**	The system shall store the identity of the user for every instance of: Data entry, Data modification, Exchange of data, Data deleted or inactivated, Report or Query requested or executed.								

CA Department of Mental Health
BH-EHR Requirements Survey
Infrastructure Requirements

Infrastructure

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
S-05	5.015	The system shall be able to detect security-relevant events that it mediates and generate audit records for them. At a minimum the events shall include: start / stop, user login / logout, session timeout, account lockout, client record created / viewed / updated / deleted, scheduling, query, order, node-authentication failure, signature created / validated, PHI export (e.g. print), PHI import, and security administration events. Note: The system is only responsible for auditing security events that it mediates. A mediated event is an event that the system has some active role in allowing or causing to happen or has opportunity to detect. The system is not expected to create audit logs entries for security events that it does not mediate.								

Infrastructure

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
S-05	5.016	The system shall record within each audit record the following information when it is available: (1) date and time of the event; (2) the component of the system (e.g. software component, hardware component) where the event occurred; (3) type of event (including: data description and client identifier when relevant); (4) subject identity (e.g. user identity); and (5) the outcome (success or failure) of the event.								
S-05	5.017	The system shall provide authorized System Administrators with the capability to review all audit information from the audit records.	Examples of audit records review include: 1) Reports based on ranges of system date and time that audit records were collected. 2) Logs exported into text format in such a manner as to allow correlation based on time (e.g. UTC synchronization).							
S-05	5.018	The system shall prohibit all users read access to the audit records, except those users that have been granted explicit read-access. The system shall protect the stored audit records from unauthorized deletion. The system shall prevent modifications to the audit records.								

CA Department of Mental Health
BH-EHR Requirements Survey
Infrastructure Requirements

Infrastructure

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
S-05	**5.019**	The system shall allow an authorized System Administrator to enable or disable auditing for groups of related events to collect evidence of compliance with implementation-specific policies.	Note: In response to a HIPAA-mandated risk analysis and management, there will be a variety of implementation-specific organizational policies and operational limits.							
S-06	**6.001**	The system shall be able to generate a backup copy of the application data, security credentials, and log/audit files.								
S-06	**6.002**	The system restore functionality shall result in a fully operational and secure state. This state shall include the restoration of the application data, security credentials, and log / audit files to their previous state.								
S-06	**6.003**	The system shall have ability to run a backup concurrently with the operation of the application, if the system claims to be available 24x7 .								
S-06	**6.004**	The system's data and program files shall be capable of being backed up by common off the shelf (COTS) backup tools.								

CA Department of Mental Health
BH-EHR Requirements Survey
Infrastructure Requirements

Infrastructure

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
S-07	7.001	The system shall include documentation to the user stating whether or not there are known issues or conflicts with security services in at least the following service areas: antivirus, intrusion detection, malware eradication, host-based firewall and the resolution of that conflict (e.g. most systems should note that full virus scanning should be done outside of peak usage times and should exclude the databases.).								
S-07	7.002	The system shall include documentation that covers the expected physical environment necessary for proper secure and reliable operation of the system including: electrical, HVAC, sterilization, and work area, if the system includes hardware.								

CA Department of Mental Health
BH-EHR Requirements Survey
Infrastructure Requirements

Infrastructure

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
S-07	7.003	The system shall include documentation that itemizes the services and network protocols / ports that are necessary for proper operation and servicing of the system, including justification of the need for that service and protocol.	Examples of services include: PHP; Web services; etc. Examples of Network protocols / ports include: HL7, HTTP, FTP; etc. This information may be used by the healthcare facility to configure their network defenses (firewalls and routers).							
S-07	7.004	The system shall include documentation that describes the steps needed to confirm that the system installation was completed and that the system is operational.								
S-07	7.005	The system shall include documentation that describes the patch (hot-fix) handling process the vendor will use for the EHR System, operating system and underlying tools (e.g. a specific web site for notification of new patches, an approved patch list, special instructions for installation, and post-installation test).								

CA Department of Mental Health
BH-EHR Requirements Survey
Infrastructure Requirements

Infrastructure

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
S-07	7.006	The system shall include documentation that explains system error or performance messages to users and administrators, with the actions required.								
S-07	7.007	The system shall include documentation of product capacities and the baseline representative configurations assumed for these capacities.	Examples of product capacities include: Number of users; Number of transactions per second; Number of records; Network load; Etc. Examples of baseline representative configurations assumed for these capacities include: Number or type of processors; Server / workstation configuration; Network capacity; Etc.							
S-07	7.008	The system shall include documented procedures for product installation, start-up and / or connection.								
S-07	7.009	The system shall include documentation of the minimal privileges necessary for each service and protocol necessary to provide EHR functionality and / or serviceability.								

CA Department of Mental Health
BH-EHR Requirements Survey
Infrastructure Requirements

Infrastructure

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
S-08	**8.001**	The software used to install and update the system, independent of the mode or method of conveyance, shall be certified free of malevolent software (“malware”). Vendor may self-certify compliance with this standard through procedures that make use of commercial malware scanning software.								
S-08	**8.002**	The system shall support key system Performance Metrics.	Example: System access and availability for all authorized users; System Response times.							

CA Department of Mental Health
BH-EHR Requirements Survey
Infrastructure Requirements

Infrastructure

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
S-08	8.006	The system shall be configurable to prevent corruption or loss of data already accepted into the system in the event of a system failure (e.g. integrating with a UPS, etc.).								
Infrastructure Totals:			Total Number of Requirements	0	0	0	0	0	0	
			96	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	

Practice Management

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-01	1.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print a unique Master Client Record.	Implies there is only one active Master Client Record at a time.							
F-01	1.002	The system shall associate (store and link) key identifier information (e.g., system ID, medical record number) with each Master Client Record.	Examples of Unique Key Identifiers Include: System-generated ID, Provider Organization-assigned Health Record Number, Governmental-assigned client identifiers. Key identifier information must be unique to the client record, but may take any system-defined internal or external form.							
F-01	1.003	The system shall be able to store more than one client identifier in each Master Client Record.	Examples of identifiers include: (e.g., Biometrics, SSN, Calif. Medi-Cal CIN, Drivers License, and State ID#). For interoperability, practices need to be able to store a minimum of 3 additional client identifiers. Examples include an ID generated by an Enterprise Master Client Index, a health plan or insurance subscriber ID, regional and/or national client identifiers if / when such become available.							
F-01	1.005	The system shall use key identifying information to identify (look up) the unique Master Client Record.								
F-01	1.006	The system shall provide more than one means of identifying (looking up) a client.	Examples of alternative identifiers include: Client date of birth, phone number, medical record number, SSN, CIN, name, and Driver's License number.							

Practice Management

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-01	1.007	The system shall be able to include or exclude client information from reporting functions.	Examples of inclusion and exclusion include: - Inclusion by payer relationship, government requirement, income level, case coordinator, etc. - Exclusion by death, transfer, relocation, etc. Being exempt from reporting is not the same as de-identifying a client who will be included in reports. Example of restricted viewing of a client identifier is Social Security Number. Inclusion or exclusion information embedded in the Master Client Record may be designed to affect all or only certain reporting functions.							
F-01	1.009	The system shall be able to merge Master Client Records.	Implies client was assigned two or more Master Client Records. Merged data may cause other client data to be merged that is demographic, financial, clinical, etc. Merging doesn't imply destruction of prior information or non-compliance with audit trail requirements.							
F-01	1.011	The system shall be able to integrate client records with information from other databases or EHR computer systems (internal or external).	Examples of Information Integration Include: Community resources listings, Client wait lists, Intake Screenings with call logging, client registrations, client referrals, and funding sources (such as CSI, PATH, SAMHSA, UMDAP). Examples of Call-Logging Data Include: Date of call, staff receiving call, name, telephone number, language requirement, referring party, and call disposition.							

Practice Management

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-01	1.013	The system shall be able to link additional client classifications to a unique client record.	Examples of Classifications Include: Client care covered by categorical funding and/or grants, High risk status, etc.							
F-01	1.014	The system shall be able to prevent multiple Master Client Records for the same client.	Example of prevention techniques includes: Checking databases for duplicate names, home addresses, data of birth, Social Security, etc.							
F-01	1.015	The system shall be able to link client identifiers with client demographic data.	Implies linkages that support required data reporting.							
F-02	2.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print client demographic data.	Examples of Demographic Information Include: Current Name, Prior name(s), Home or work address; Phone number(s); E-mail addresses; Date of Birth; Contact information for client relatives, friends, or other care advocates; Alternative methods of contact (e.g., alternate addresses, alternate phone numbers, etc.); Etc. It is assumed that all demographic fields necessary to meet legislative and regulatory (i.e., HIPAA), research, and public health requirements will be included. Input may include various types of data including: Free text, multiple choice, and drop-down menu items. See 43.040.							
F-02	2.005	The system shall be able to store client demographic information in separate discrete data fields, such that data extraction tools can retrieve these discrete data.								
F-02	2.009	The system shall be able to merge separate client demographic data records.								

Practice Management

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-02	2.010	The system shall be able to display and review all data in two similar type client demographic records for the same client, identifying the data that is different.	This will support determining the client demographic information that should exist subsequent to merging two records to one.							
F-02	2.011	The system shall be able to require user confirmation prior to merging any client demographic information.								
F-02	2.012	The system shall be able to create separate records from client demographic records erroneously merged.								
F-02	2.013	The system shall be able to register clients who will receive minimal care.	Implies requiring fewer mandatory fields to be completed.							
F-02	2.014	The system shall be able to capture limited pre-registration information when full registration cannot be completed.								
F-02	2.015	The system shall be able to store both permanent and temporary client addresses.								
F-02	2.017	The system shall be able to navigate between client registration and other screens without loss of registration data already inputted.	Examples of other screens: Scheduling, billing, client identifier lookup, and service / treatment records lookup.							
F-02	2.019	The system shall allow clients to input data.	Example data includes: demographic, insurance information, family history, social history and prior medical history. Such data entry may occur via Internet Web interfaces, an in-office kiosk, etc..							

Practice Management

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-15	15.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print client consents and authorizations.	Implies handling of: Hardcopy signatures; Electronic Signatures; Refusal to sign notations; Etc. Includes supporting follow up processes to obtain missing client signatures. Consents and authorizations may be: Sent electronically, Associated with a specific clinical activity, Displayed chronologically, input in a variety of methods (e.g., scanned) Implies timely review capacity and HIPAA compliance. See Practice Management 43.006 and Infrastructure 43.040.							
F-15	15.005	The system shall be able to store and display administrative authorizations.	Examples of Administrative Authorizations Include: Privacy notices, etc. Needed for HIPAA. Scanned copy is acceptable for 2007.							
F-15a	15a.01	The system shall provide the ability to indicate that a client has completed advanced directive(s).	Important for appropriate use of resources at end-of-life and may just include a Yes/No indication.							
F-15a	15a.02	The system shall provide the ability to indicate the type of advanced directives, such as living will, durable power of attorney, or a "Do Not Resuscitate" order.	This may be recorded in non-structured data or as discrete data.							
F-15a	15a.03	The system shall provide the ability to indicate when advanced directives were last reviewed.	This may be recorded in non-structured data or as discrete data.							

Practice Management

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-20	20.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print non-medication referral orders with detail adequate for routing.	This could include referrals to sub-specialists, physical therapy, speech therapy, nutritionists, and other nonmedication, nonclinical orders. Adequate Detail Includes, But Is Not Limited To: Date; Client name and identifier; “Refer to” specialist name, address, and telephone number; “Refer to” specialty; Reason for referral; Referring physician name; etc.							
F-20	20.002	The system shall be able to record user ID and date/time stamp for all referral-related events.	Necessary for medico-legal purposes. Security							
F-20	20.004	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print consultation and referral forms.								
F-24	24.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print inter-provider communication.	See Practice Management 43.012 and Infrastructure 43.040.							
F-26	26.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print healthcare service provider demographic information in a directory of healthcare service providers.	Examples of Healthcare Service Providers Include: Health Providers internal or external to the organization responsible for the EHR system. Examples of Demographic Information Include: Provider name, provider location, salaried or contract employment, credentials, language, days and times worked, service specialties, languages spoken, training accomplished, contact information, effective Start / Stop Dates, etc. Examples of Credentialing Include: State licensures (MD, MFCC, LCSW, MFT, LPT, etc.), DEA, and NPI numbers. Credentialing and Certification data shall include Effective and Expiration Dates.							

Practice Management

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-26	26.003	The system shall validate, at the point of service entry, that the rendering healthcare service provider is credentialed to provide the service / treatment.	For example, health care service provider is, or is not, credentialed to perform medical medication support service / treatments.							
F-26	26.009	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print healthcare service providers system attributes.	Examples of Healthcare Service Provider System Attributes Include: Relationships to specific fee schedules, specific health plans, specific procedure codes, or groupings of these attributes.							

Practice Management

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-27	27.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print information of an Electronic Scheduler.	Examples of Electronic Scheduler functionality include: System wide access; Scheduling of clients, healthcare service providers, interpreters, space, equipment, vehicles, and other resources; Inquiries such as "find first available appointment for Dr. X"; Multi-month advance scheduling for client services and medication management; Entry of recurring appointments, staff comments, and reason for appointment; Overbooking management; User notifications / warnings of potential appointment problems; Assigning resource non-availability; Many to one (providers to client) scheduling, and cancelling, rescheduling or other modification of existing appointments; Modification of appointments to show them as missed, re-scheduled or completed appointments; Interface with charge entry system(s); Interface with Client Appointment Waiting List system(s). Examples of scheduler information include: Client name, client chart number, client date of birth, client gender, client appointment date / time, client telephone number and address, provider name, client co-pay due, service / treatment authorization expiration dates, insurance expiration dates, etc. Scheduler data may be populated either through data entry in the system itself or through an external application interoperating with the system.							

Practice Management

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-27	27.027	The system shall be able to communicate language-appropriate scheduling information to clients.	Examples of scheduling information include: Email, letters, address labels, notices, reminders, phone messages, etc. Examples of reasons for communication include: Missed, canceled, scheduled, or rescheduled appointments; Appointment related follow up communication. Includes automated communication protocols such as: auto-telephone messages and auto e-mail.							
F-27	27.038	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print information of a Client Appointment Waiting List.	Similar to Electronic Scheduler comments.							
F-27	27.041	The system shall be able to display or print information on clients who missed or cancelled appointments.	Displayed / printed information may: Be bound by a user-selected date/time period; Include reasons for cancellations.							
F-27	27.044	The system shall be able to print a charge ticket (super bill) before the appointment or when the client arrives and checks in.								

Practice Management

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-28	28.001	The system shall be able to generate reports based on existing, or missing, healthcare service, financial, and administrative data.	Implies: Both adhoc and scheduled reporting capability; Ability to Interface to internal and external reporting tools. Reporting Examples Iinclude: Reports on multiple clients (i.e., group therapy); Monthly trend reports; Client Diagnosis analysis reports; Healthcare service provider comparison reports: Cost reporting; Usage of disease registries; Usage of standard reports; Usage of complex reporting data queries; Capability to report on all data in the system; Capability to export data to other electronic office formats (e.g., MS Excel, MS Access, etc.); Reporting with multi-layered data sorts; Usage of "wild cards" in report selection parameters; Computation based on system information and report parameters; Analysis related to medications and service / treatments; "Dashboard" reporting; Missing data reports. Examples of Missing Data Reports: A lab test has not been performed or a blood pressure has not been measured in the last year.							
F-28	28.004	The system shall allow users to specify report parameter variables (e.g., sort and filter criteria).	Example Variables: 1) Client Demographic and Clinical Data (i.e., all male clients over 50 that are diabetic and have a HbA1c value of over 7.0 or that are on a certain medication). Minimum demographic data are age and gender. 2) Data date ranges. 3) Program Type. 4) Organizational Department. 5) Provider. Examples of Data Date Ranges Include: One or more times per day, weekly on specified day, monthly on first day of month and fiscal period, etc. Includes modifying one or more parameters of a saved report specification.							

Practice Management

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-28	28.005	The system shall be able to upload, download, and access report information.	Examples include: Access to print files data output; Upload and download of plain text, MS Excel, Adobe PDF, and XML file formats.							
F-28	28.007	The system shall be able to save report parameters for generating subsequent reports.								
F-28	28.009	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print a variety of outcome measurement instruments.	Includes using locally-defined and third-party licensed scoring protocols to summarize outcome instrument data.							
F-28	28.011	The system shall allow on-line clinical review of outcome score trends over time.	This capacity is intended to support clinical decisions.							
F-28	28.013	The system shall be able to report in various formats.	Includes reporting to different media, (E.g., Screen displays, Printed paper, and electronic files) Examples of formats include: ASCII , XLS, CSV, PDF, MDB, TXT, DIF, XML, etc.							
F-28	28.014	The system shall allow report specifications to be copied, edited and added to the reports menu with a new report name.	Storage location of report specifications and created reports should be able to be configured by the individual facility.							
F-28	28.016	The system shall support the collection, compilation, reporting and analysis of all mandated outcomes.								
F-28	28.017	The system shall support reporting and data analysis of the County's Quality Assurance Programs.	Quality Assurance: The development and production of reports based on Payor- and County-identified performance and outcome measures for access, assessment, service/care planning, service / treatment delivery, etc. Also aids random chart sampling and review processes.							

Practice Management

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-28	28.018	The system shall support reporting and data analysis of the County's Quality Improvement Programs.	Quality Improvement: The development and production of reports that track and trend quality measures over time and can support the identification of variation that is material and statistically significant.							
F-28	28.019	The system shall support reporting and data analysis of the County's Utilization Review Programs.	Utilization Review: The development and production of reports that track utilization throughout the county and identify specific clients, clinicians, service / treatments, and/or programs that are above or below user-designated trigger thresholds.							
F-28	28.022	The system shall be able to measure system performance impacts due to the execution of reports simultaneous to other system operations.								
F-28	28.024	The system shall be able to interface with SQL-compliant third-party report writer applications.	Examples of Third-Party Report Writers Include: Crystal Reports, Microsoft Access, R&R Report Writer, etc.							
F-28	28.025	The system shall support a letter-writing/mail merge function.	Examples of merge includes: Microsoft Word integrated with the system to produce letters to clients, clinicians and other parties.							
F-28	28.026	The system shall support letter templates.	Examples of Support Include: Automated generation of a referral letter; generation of a follow-up client letter when an appointment is recorded as a missed appointment.							
F-28	28.028	The system shall support the export of production database data to a reporting server or data store.	Implies support for maintaining integrity of production data and improving system performance.							
F-28	28.031	The system shall be able to display and print database documentation.	Examples of Database Documentation Include: A complete data dictionary and Entity Relationship Diagram of all of the tables, table relationships, fields, and field attributes.							

Practice Management

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-28	28.032	The system shall support drill-down reporting to examine the underlying data behind figures on report displays.	Common to "Dashboard" reporting.							
F-28	28.034	The system shall provide predefined views of data sets that merge data from multiple tables into logical reporting groupings.	Examples of Predefined Views Include: Predefined by Clients; Predefined by healthcare service providers; Predefined by administrative staff; Predefined views including service / treatments, service / treatment authorizations; Etc. Predefined views assist nontechnical users in creating new standard, management, and ad hoc reports.							
F-28	28.035	The system shall be able to report by groupings of client demographics data.	Examples of grouping include: User-defined population cohorts, geographic clusters of ZIP codes, groupings of client eligibilities, etc.							
F-28	28.036	The system shall support bidirectional transfer of data between business associates.	Examples of business associates include: State and County or County to County							
F-28	28.037	The system shall be able to report data through national healthcare electronic transaction standards.	Examples of national standards include: HL-7 and ASC X12N transactions; support the translation of data sets based on predefined translation code tables; support the development of error-checking routines, flagging via error reports, and the ability to readily resolve nonmatching data.							
F-28	28.038	The system shall be adaptable to specification changes from payors, and other business associates.								
F-28	28.039	The system shall support client satisfaction surveys reporting.	Implies scheduled and on-demand surveys.							
F-30	30.016	The system shall be able to notify user immediately of data entry validation errors.	Examples of Data Entry Validation Include: Authorized practitioner scope of practice, service site, department, service provider, etc.							

Practice Management

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-30	30.021	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print client service / treatments, including those that are group based.	Implies participants in a group may be coordinated by several different teams within the same agency; groups can easily be created or modified. Implies when service / treatments are entered for a group, all group members are to be displayed for rapid data entry. Implies data entry retrieval by date, client identifier, service / treatment type, provider identifier, diagnosis, referred provider, client care funding, and client financial liability, etc.							
F-30	30.022	The system shall allow for multiple healthcare service providers in a group to have different billing and documentation times per client service.								
F-31	31.002	The system shall be able to select, or offer choice, of an appropriate billing code and billing fee based on data input for, or supporting, a client service / treatment.	Examples of choice inlcude:: Selection of a CPT Evaluation and Management code based on provider documentation. May be accomplished via a link to another application.							
F-31	31.004	The system shall provide the ability to interface the most current procedure code with the current service/Care Plan.								
F-31	31.005	The system shall support financial and administrative rules that allow posting charges for more than one day for one client on one screen.								

Practice Management

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-31	31.009	The system shall support financial and administrative rules that allow exporting charges to a current or future practice management system.								
F-31	31.010	The system shall support financial and administrative rules that ensure actual payor charges match the clinical charting.								
F-31	31.015	The system shall have the ability to provide a list of financial and administrative codes.	For example, ICD-9 CM, ICD-10 CM, and CPT-4 codes.							
F-32	32.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print eligibility data obtained from a client's third party payor.	Implies participants in a group may be coordinated by several different teams within the same agency; groups can easily be created or modified. Implies when service / treatments are entered for a group, all group members are to be displayed for rapid data entry. Implies data entry retrieval by date, client identifier, service / treatment type, provider identifier, diagnosis, referred provider, client care funding, and client financial liability, etc.							
F-32	32.004	The system shall be able to process retroactive health plan eligibility.	Implies that a new eligibility record is added to the system for each client monthly Medi-Cal eligibility, including all retroactive additions to Medi-Cal.							
F-32	32.005	The system shall be able to comply with electronic transmission of HIPAA-Compliant Eligibility Determination, Enrollment and Disenrollment formats.	Implies usage for benefit eligibility determination in Medi-Cal, Medicare, Insurance, and other third party payor systems.							

Practice Management

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-32	32.007	The system shall support Medi-Cal eligibility evaluation of registered clients..	Examples of Evaluation Support Include: For clients with no Third-Party coverage reporting their full names, identification information, and all encounters / charges within a user-specified date range; Obtaining financial screening information necessary for determining Medi-Cal eligibility; etc. Evaluation may be ad hoc or scheduled daily, weekly, monthly, etc.							
F-32	32.009	The system shall support the manual on-line review and update of insurance records, as necessary.	Examples of Special Handling Conditions Include: Partial eligibility match requiring investigation, Clearing Medi-Cal Share-of-Cost responsibility, CMSP eligibility, other State aid codes, Medicare, private insurance, and Medi-Cal clients with a different responsible county.							
F-32	32.015	The system shall integrate Medi-Cal eligibility assessments processes with eligibility referral systems.								
F-32	32.016	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print data required for the support of various pharmaceutical company indigent client, “Patient Assistance Programs (PAP)".	Patient Assistance Programs support indigent healthcare.							
F-32	32.017	The system shall be able to generate medication-specific "Patient Assistance Programs (PAP)" applications forms to request medications at no cost from manufacturers.	Implies different application forms for multiple Patient Assistance Programs							

Practice Management

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-32	32.019	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print "Patient Assistance Programs (PAP)" forms and the status of related pending applications.								
F-33	33.001	The system shall be able to identify by name all healthcare service providers associated with a specific client service / treatment.	A healthcare service provider is defined as anyone delivering clinical care such as physicians, PAs, CNPs and nurses; the provider is the person who completes the note.							
F-33	33.002	The system shall be able to specify the role of each provider associated with a patient, such as encounter provider, primary care provider, attending, resident, or consultant.	This is simply meant as a means to define the provider role. Display of that data is not addressed.							
F-33	33.003	The system shall be able to display and print the primary or principal provider responsible for the care of a client within a care setting.								
F-33	33.004	The system shall be able to create a list of all clients who have had a service / treatment with a given healthcare service provider.								
F-40	40.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print all mandated reporting data.	Examples of Mandated Reporting Data Areas Include: California CSI, DCR, and OSHPD reporting.							
F-40	40.002	The system shall be able to import and integrate external mandated reporting data.	Examples of External Mandated Reporting Data Areas Include: DCR and Cost-Reporting. (XML Schema Definition files, etc.)							
F-40	40.004	The system shall be able to produce reports based on absence of mandated data elements.								

Practice Management

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-40	40.006	The system shall be able to generate error or suspension reports prior to submission of a mandated report.								
F-40	40.007	The system shall be able to specify the output file format for mandated reporting.	Examples of file formats include: XML, CSV, etc.							
F-40	40.008	The system shall be able to produce all mandated reports.	Examples of mandated reports include: DMH EOY Cost Reporting, CSI & OSHPD, MHSA, PATH, and SAMHSA Reporting.							
F-40	40.009	The system shall be able to translate healthcare service provider coding into required reporting formats.	Examples of Data Coding Include: Ethnicity codes, Gender, etc. Implies automated and manual translation capability.							
F-40	40.011	The system shall support validation of mandated reporting data.	Examples of validation include: Verifying date of service / treatment consistent with provider employment or contract period; Treatment / Service meets any authorization requirements; Reporting adheres to all mandated reporting rules; Target population for reporting matches system data attributes, Etc.							
F-40	40.012	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print healthcare service Treatment Authorization Requests (TARs).	Examples include both Inpatient and Outpatient TARs.							
F-40	40.013	The system shall be able to input modify, inactivate, delete, update, display, copy, and print client care episodic data.	Examples include: Inpatient and Outpatient episodes data; Related Utilization Review notes; User-defined checklists; Daily census and bed statistics; etc.							
F-41	41.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print Accounts Payable information.	Examples of Accounts Payable information include: Receiving HIPAA 837 and 997 transactions; Receiving hardcopy health claims information;							

Practice Management

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-41	41.002	The system shall be able to adjudicate health claims payment-related requests.	Examples of Health Claims Payment-Related Requests Include: Receiving HIPAA 837 and 997 transactions; Receiving hardcopy health claims. Examples of Adjudication Basis Include: Payee eligibility; Client eligibility; Insurance plan priority for sequential payors; Date of service; Service or provider authorization; Covered diagnosis; Fee schedules; etc. Examples of Requirements Include: Reimbursement by case rate, fee for service, capitation, fixed fee payments; etc. Examples of Adjudication Process Include: Printing of hardcopy Explanation of Balance (EOB) information when appropriate; User-defined letters to issue to health claim providers; etc.							
F-41	41.003	The system shall be able to adjudicate health claims to a per claim line basis.	Implies automated and manual adjudication capability.							
F-41	41.005	The system shall transmit HIPAA-compliant transactions in response to receipt of incoming HIPAA-compliant transactions.	Examples of HIPAA-compliant transactions include: ASC X12N 835 - Healthcare Payment and Remittance Advices							
F-41	41.006	The system shall be able to forward External Provider ASC X12N 837 Health Claims to claim payors.	Examples of claim payors include: Short-Doyle Medi-Cal, Medicare, Insurance, and other providers (such as other Counties).							
F-41	41.007	The system shall be able to pend claims for review and subsequent approval or denial.								

Practice Management

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-41	41.008	The system shall be able to integrate with an accounts payable system that supports EHR related claiming.								
F-41	41.010	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print Accounts Payable (A/P) claim payments, denials, and adjustment transactions.	Examples of Adjustments Include: Claim A/P entries that are to be reversed; Credit balances cleared; etc. Implies that adjustments shall also be included in related Remittance Advices.							
F-41	41.011	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print A/P audit trail transactions.	Implies ability of an audit trail for all A/P transactions; integration with Audit Trail business rules.							
F-41	41.012	The system shall be able to input, modify, inactivate, delete, update, copy, and print payment and denial information from providers related to coordination of benefits.								
F-41	41.014	The system shall be able to limit EHR-related claims by claim payment limits.	Examples of Limits Include: Total contract amount; Fee Schedule Maximums; Contract term; etc.							
F-41	41.015	The system shall be able to display and print claim information by various criteria.	Examples of Criteria Include: Vendor identification, Payor source, Payment amount, Denial or approved status, Client identification, etc.							
F-41	41.016	The system shall be able to generate required Internal Revenue Service (IRS) Form 1099 documents each calendar year end.								

Practice Management

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-41	41.018	The system shall be able to reimburse payors due to A/R adjustments.	Reimbursements may be due to overcharges, overpayments, incorrect service / treatment entry, incorrect software application routines, therapeutic adjustments, etc.							

Practice Management

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-42	42.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print Accounts Receivable (A/R) transactions information.	Examples of A/R transactions input methods include: Electronic ASC X12N 835 - Payment and Remittance Advice data; Hardcopy A/R data; Etc. Example of A/R Transactions Include: Charge, payments, and adjustments. Examples of Transactions Information Include: Payor source; Payment reason; Contractual allowance amount; Sliding-scale discount amount; Incorrect fee adjustment; Therapeutic adjustment (authorized by County Mental Health Director); Bad debt write-offs; Client identification; Account identification; Name of the person who posted the transaction; Posting date; Transaction type; Transaction amount; Updates to account balances; etc. Examples of Adjustments Reasons Include: Service / treatment costs adjustments due to capitated or grant-in-aid funding streams; Medicare adjustments due to "accepting assignment"; Retroactive health plan enrollment (e.g., Medi-Cal, Medicare, and private insurance); client sliding-fee scale liability changes (e.g., UMDAP); etc. Examples of Transaction Processing Include: Automated, manual, real-time, batched, scheduled and adhoc posting; posting that minimizes repetitive keystrokes; Payments posted though there are no related charges; Payments / Charge matching suspended though payments posted; Running totals that allow verification that individual payment detail postings matches check or remittance advice total; Receipt posting to a specific month of service/treatment,							

Practice Management

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
			oldest balance or to individual open items; Linking transactions to client accounts and to specific charges/invoices. Posting of multiple client transactions by same payor; Notification of discrepancies in transaction posting, Linking transaction a payment or adjustments category (type); A/R linkage to A/P payments for required payor reimbursement; Adjustments to client account balances (including UMDAP); etc. Input implies integration of A/R data with related EHR system functions.							
F-42	**42.002**	The system shall be able to transmit and receive A/R health claims information.	Examples of A/R information include: HIPAA 837 and 997 transactions; "Passing through" claims data to another healthcare services provider; ASC X12N 835 transactions; Other uploads and downloads such as client UMDAP liability; Etc.							
F-42	**42.003**	The system shall provide accounts receivable support for cost reporting requirements.	Examples of Accounts Receivable Support Include: Translations to mode of service and service function codes; Unit of service calculations based on minutes; Limitations per Scheduled Maximum Allowance (SMA); Legal Entity & Provider Codes; Revenue classifications such as Healthy Families, AB3632, EPSDT, Medi-Cal, Medicare, Medi-Cal / Medicare, Indigent, etc. Examples of Required Reporting: DMH EOY Cost Reporting, CSI & OSHPD, MHSA, PATH, and SAMHSA Reporting.							
F-42	**42.005**	The system shall be able resubmit or to correct, then resubmit Health Claims.	This requirement allows rebilling payors for lost claims, etc., as well as void, replacement, correction and resubmission of claims previously denied by the health claim payor.							

Practice Management

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-42	42.008	The system shall be able to print paper-based A/R claims information.	Examples of Paper-based A/R Claims Include: HCFA-1500, UB-92 and user-defined formats; ad hoc or scheduled printing. This includes claims which are forwarded electronically to the County from contract providers for submission to payors and the corresponding forwarding of remittance advices back to the contract providers.							

Practice Management

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-42	42.009	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print all required A/R business rules.	Examples of Areas of A/R Rules Include: Third-Party Payor rules (e.g., Medicare, Medi-Cal, Insurance); Service / treatment authorization; Benefit limits; Deductibles; Co-pays; Service / treatment coverage; Required payment write-offs; Documentation requirements complete prior to billing; Reimbursement methods (e.g., Fee-for-service, case rates, per diem, capitation, and the bundling and unbundling of service / treatment codes by payor); Fee schedule rules (e.g., County Board of Service approved fees; UMDAP fees, CalWorks, Healthy Family, Federally Qualified Health Center (FQHC), and Refugee Population programs fee rules; Multiple payor fee prioritization, fee effective start/stop dates; Fee type (e.g., fees per program, payor, contractual agreements; Ensuring that revenue and A/R balances do not overstate outstanding amounts by reporting balances for multiple payors simultaneously; Sending follow-up reports to staff based on transaction notes information; Most recent assigned client diagnosis becomes the default global client diagnosis used for current A/R purposes; Data validation; Automatic translation of health care provider coding into required accounts receivable related claiming or reporting formats; etc. Implies fee schedules are interfaced with other EHR systems. Examples of Medi-Cal billing Rules Include: Preventing billing for clients that have no known Medi-Cal eligibility during the month of service / treatment, Clients who have not met Medi-Cal Share of Cost liability; Healthcare provider documentation that is incomplete; Duplicate claiming; Clients who reside in an Institute for the Mentally Diseased (IMD), Board and Care costs on a Psychiatric Health Facility, etc.							

Practice Management

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-42	42.010	The system shall be able to enforce all required A/R business rules.	Implies system has capability for automatic and manual calculation of all client benefit-plan(s) co-pays and deductibles. Examples of payor sources with billing rules include: Medicare, Medi-Cal, Insurance, California State funding programs (E.g.., CalWorks, SAMHSA, PATH, MHSA FSP, AB3632/26.5 and MIOCR funding sources; California Specific AB3632 (where payments are limited to those service / treatments authorized in a youth's Individualized Education Program (IEP) authorization); Examples of required billing rules may be found in a variety of sources such as: CA DMH Information Notices; CA DMH Letters; CA DMH HIPAA 837 Companion Guide; CA DMH CSI manuals; Federal OMB Circulars; and Federal Medicare Guidelines.							
F-42	42.020	The system shall be able to display and print payor billing invoices.	Examples of Client Billing Invoice Content Include: Appropriate UMDAP-related fees; Medi-Cal Share-of-Cost charges; One bill has charges for all service / treatments provided within the billing invoice date range. Invoice printing may be ad hoc and scheduled.							
F-42	42.027	The system shall support client liability collection processes.	Implies automated and manual collections support processes. Examples of Collection Support Include: Documentation of attempts at obtaining client outstanding liability and support for adherence to provider A/R debt transfer protocols; Support for related tickler systems; Transfer of client account to collections; Reporting on A/R related contract dates, collections notes, and grouping of payors for collections purposes.							

Practice Management

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-42	42.029	The system shall be able to display and print billing statements.	Implies adhoc and scheduled billing statements,Creation of user-defined billing statement formats.							
F-42	42.030	The system shall be able to prevent printing of client billing statements and client invoices, and note the reason.	Implies client bills will have all applicable charges, payments and adjustments. Examples of Reasons to Prevent Billing Are: Management billing overrides; AB3632 eligibility; Clients who have Medi-Cal coverage shall not receive statements; Entire client billing processes suspended; Awaiting a response from a third-party payor; Research on client accounts underway, etc.							
F-42	42.031	The system shall be able to redirect client billing statements.	Examples are: Redirection of client statement to the client/guarantor, the client's conservator, or both.							
F-42	42.032	The system shall be able to place messages in client billing statements.	Examples are: Culturally appropriate billing warnings, payment thank-you messages, and healthcare service provider messages.							
F-42	42.034	The system shall be able to display and print an audit trail of client billing invoices and statements.								
F-42	42.038	The system shall support estimated costing of all provider service / treatments rendered (direct and indirect service / treatments).	The estimated cost of a direct service / treatment for a client is typically determined as stated in Standard fee setting requirement above. Estimated cost of either direct or indirect service / treatment is intended to assist the provider in managing or reporting on estimated year end service / treatment or program costs. Usage of this capability will be provider specific.							
F-42	42.039	The system shall be able to compare service / treatment fees to the related Statewide Maximum Allowance (SMA) set by the CA DMH.	The SMA is a SD/MC rate cap which is updated annually by CA DMH.							

Practice Management

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-42	42.044	The system shall be able to issue sequentially numbered payment receipts.								
F-42	42.048	The system shall support controls for reconciling A/R postings.	Examples of Support Include: Ad hoc or scheduled printing of receipts information regarding Posting staff, service / treatment, provider organization, date range, site, service / treatment charges, total deposit amount, bank and check numbers, etc.							
F-42	42.051	The system shall support that outstanding charges remain as an open receivable until paid or adjusted.								
F-42	42.052	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print A/R audit trail transactions.	Implies ability of an audit trail for all A/R transactions; integration with Audit Trail business rules.							
F-42	42.055	The system shall display and report Aged A/R data.	Examples of Reporting Include: Ad hoc and scheduled displays or reports; reports of claims paid, claims denied, claims in suspense, claims re-billed; Detailed aged accounts receivables by user-defined sorts and subtotal criteria including payor, provider, client, program, location; Reporting by selected date ranges, etc.							

Practice Management

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-42	42.057	The system shall be able to display and report A/R transaction history information.	Examples of Account Transaction History Include: Charges, Payments, Guarantor information, Account status codes, Account balances, Assignment acceptance, Effective Start/Stop Dates, Transaction adjustments, Provider and support staff notes attached to A/R transactions, etc. Displays and reports may be configured for accrual versus cash basis, selected payors and date ranges. Examples of Displays and Reports Management Include: Filtering to show the same information for a single payor (including client responsibility), A/R status displays on various system screens such as those for client registration or scheduling. Examples of Reports Include: Revenue analysis reports by provider, service / treatment type, funding source, program, etc; Claim status reports; Insurance or Provider comparison reports; Credit Balance Reports; Bad debt reconciliation reports; Client refund reports; Outstanding Balance reports summarizing inactiviity; Overdue payment report; Payor Denial reports, Non-Sufficient Fund payment reports; Capitated Funded Clients listing; and Daily transaction log report. Daily transaction logs may be organized by patient name in alphabetical order or by account number, and include: Date of service/treatment, posting date, provider's name, transaction description, transaction type, and transaction							
F-42	42.058	The system shall be able to attach notes to A/R transactions.	Examples of A/R notes include: Notes regarding collection calls to clients; Client verbal consents regarding account payments; Follow-up notes to provider staff; etc.							

Practice Management

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-42	42.089	The system shall be able to provide A/R notifications and messages to users.	Examples of A/R Notifications and Messages Include: Prompting user with client payor-specific questions, Displaying comments or flags indicating client-related information, Billing information to relate to client during client appointment, etc.							
F-42	42.099	The system shall support single source billing.								
F-42	42.102	The system shall support client directed billing rules.	Examples of Support Include: Billing or not billing for AB3632-related children services, Monthly payments on annual UMDAP liability, etc.							
F-42	42.107	The system shall support compliance with Generally Accepted Accounting Principles (GAAP).								
F-42	42.113	The system shall be able to prevent entering non-valid A/R data.	Examples of Prevention Include: Preventing posting A/R data to the wrong open receivable, provider, service, client, etc.							
F-42	42.121	The system shall be able to follow mail specifications of the US Postal Service.	Examples of mail specifications include: Printing ZIP+4 and bar coding requirements.							
F-42	42.124	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print information regarding accounts in collections.								
F-42	42.125	The system shall generate collection letters.	Implies ability to create / use collection letter templates.							
F-42	42.142	The system shall be able to inform A/R staff of client data changes made outside A/R scope of practice but which affect A/R processes.	Examples of Changes Include: Client address changes; Name changes, etc. System rules may allow automatic updates of A/R system data.							
F-42	42.147	The system shall support double entry accounting.								

Practice Management

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-42	42.154	The system shall support general ledger journal entries.	Examples of support include: Detailing revenue, adjustments, payments, bad debts, and refunds by account number (segmented by site and department).							
F-43	43.001	The system shall support accounting for all daily staff work time.	Examples of Staff Time Include: Client-related and nonclient-related activities.							
F-43	43.002	The system shall be able to input, modify , inactivate, delete, update, display, copy, and print critical incidents.	Examples of Critical Iincidents Include: Critical incidents occurring in client's life or client care. Examples of Support Include: Data entry which "triggers" critical incident reporting / messaging according to staff responsibilities. Examples of Staff Responsibility Areas Include: Clinical, administrative, and financial.							
F-43	43.004	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print information of a personal task list.	Examples of Information in a Personal Task List Include: Client appointments for the day; Staff meetings; QI reminders on record problems; Automated alerts (i.e., time to renew a service/Care Plan). The personal task list may be interfaced with third-party products. See 43.009, 43.010, and 43.012.							
F-43	43.005	The system shall be able to input, modify , inactivate, delete, update, display, copy, and print documentation related to local policies and procedures.	Implies documentation may be accessed by standard office word processing software (E.g., Microsoft Word).							

Practice Management

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-43	43.006	The system shall support efficient and user-friendly workflows.	Efficient implies reducing staff time to complete system operation. User-friendly implies high user-acceptance of system interfaces and information displays. User-Accpetance May Include: Easy ability to navigate screens; add data record fields; interface to third-party software products (e.g., Microsoft Excel & Word); ability to have automatic updates of reference information (done through internal or external software linkages); ability to create / configure data displays, entry forms and system data linkages; etc. Examples of System Function Data Linkages Include: Scheduler may cause message routing, Assessments may engage access to Best Practice guidelines, Attempts to access data may cause messages to providers, Treatment data may be seen in Episode data screens. Displays and printing may be ad hoc or automated per buisness rules (unless otherwise stated). Example Workflow Areas Include: Quality management functions; Client, customer or provider satisfaction surveys; Complaint and compliment forms, Referral functions; and user-definable screen configurations or data fields, etc.							

Practice Management

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-43	43.009	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print all required Workflow Business Rules.	Examples of Business Rules Support Include: Workflows that are controlled or "guided" ("guided" implies user choice) by system implemeted business rules. Example Business Rules Areas Include: Documents creation or mainpulation; Following standard procedures related to critical incidents and staff advisories; Client pre-registration or registration; Client screening and admission; Client discharges; Client referrals; Client billing; Handling of client Medi-Cal Share of Cost; Client call logging; Referrals; Message, notification, alert, or document routing protocols; Signature acquisition protocols; Decision support; Diagnostic support; Workflow control; Access privilege; Data manipulation (e.g., creation, modification, deletion, inactivation, obsolescence, tranfer, etc.); Audit trail management; Work assignments; Task lists; Human resources,; Work prioritzation; Work re-direction; Work reassignment; Client instructions linked to specific conditions (e.g., diagnosis, client preferences, etc.); "Escalation" of alerts, notifications, reminders, and tasks; etc. Examples of "Escalation" include forwarding information to supervisors / managers, display highlights, and increasing frequency of information display, etc. See 42.009 and 42.010							
F-43	43.010	The system shall be able to enforce all Workflow Business Rules.								

Practice Management

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-43	43.012	The system shall be able to input, modify, inactivate, delete, update, display, print, and route messages, alerts, notifications, and documents to system users, providers and clients.	Examples of Information in Messages, Alerts, Notifications and Documents Include: Information, action, etc., are due or overdue, due dates; service / treatment authorizations; Incomplete client assessments, service/Care Plans, progress notes, or discharge summaries; Missing signatures; Loss of Third-Party Payor eligibility; Client advisories; Tasks information detail, Follow-up letters; Health information request; Etc; Alert configurations may include length of advance timing and who should be alerted. Examples of Support Include: Automated or manually created e-mails, text displaying in pop-ups, links to documents, Ad hoc and scheduled messages; Adherence to Best Practice standards; etc.							
F-43	43.018	The system shall support client referrals.	Examples of support include: Referrals to Business Associates by HIPAA ASC X12N 278 - Referral Certification and Authorization format; Client referrals to other providers in same organization; Client referrals to other staff supporting client care, Client referrals to other county departments, etc.							
F-43	43.021	The system shall support accessing community resource databases.	Examples of Support Include: Uploading or manual entry of community resources information into a searchable database that can be filtered based on user criteria; Integrating with or keeping community resource information separate from other organizational provider directories; etc.							
F-43	43.023	The system shall support moving clients from a Wait List to service / treatment.	Example of Support Includes: Tracking and sorting prospective clients by priority to assist in moving individual into service / treatment; etc.							
F-43	43.025	The system shall support a Grievance and Complaints system.								

Practice Management

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-43	43.026	The system shall support client admission and discharge.	Examples of Support Include: User-defined online admission/discharge forms; Episodic discharge due to automated driven reviews of client inactivity; Coordination of system function for client admissions and discharges occurring on same day; etc.							
F-43	43.027	The system shall support transfers of client information.	Examples of Support Include: Real-Time and Batched information transfer; Transfers of data internal to EHR system; Transfer of data between Business Associates; Transfers that are HIPAA compliant; Culturally-appropriate information transfers; etc.							
F-43	43.028	The system shall ensure that workflows are compliant with federal, state, and local laws, rules, and regulations.								
F-43	43.031	The system shall support 24-hour client care.	Examples of Support Include: Creation, modification, deletion, and review of client related data; Tracking of clients by unit, room and bed, and midnight bed checks; Using the information to generate daily room charges; Monitoring facility capacity and documents bed availability; Tracking of dietary requirements for each 24-hour patient by unit, room, and, bed; Dietary orders for the kitchen based on the dietary orders; Monitoring of client valuables placed in 24 hour care; etc.							
F-43	43.035	The system shall support single sign-on software products.	Implies maintaining internal security controls.							
F-43	43.037	The system shall be able to auto-populate data fields with client demographics.	May include user definition of which data will be auto-populated.							
Practice Management Totals:			**Number of Requirements**	**0**	**0**	**0**	**0**	**0**	**0**	

Practice Management

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
			162	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	

Clinical Data

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-03	3.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print all client problems information.	Examples of problems information include: Problems Descriptions; Problems Lists; Diagnosis: Name; Coding; Active / inactive status; Associated information (e.g., admission, discharge, chronicity, acute/self-limiting, Etc.); Family type (E.g.., ICD-9 CM, ICD-10 CM, SNOMED-CT, DSM-IVR; Etc.); ; Effective Start / Stop dates for diagnosis; Etc. Displays should be user-friendly (e.g., Display of both diagnosis code and name; option to display diagnosis description; Etc.) See Practice Management 43.006 and Infrastructure 43.040							
F-03	3.002	The system shall provide the ability to maintain a history of all problems associated with a client.	This means both current and inactive and/or resolved problems. These may be viewed on separate screens or the same screen. Ideally each discrete problem would be listed once.							
F-03	3.005	The system shall be able to record the user ID and date of all updates to documented client problems.								
F-03	3.006	The system shall be able to associate orders, medications, and care documentation (e.g., notes) with one or more problems.	Implies ability to associate a visit with a particular diagnosis / problem. Association may be in a structured or non-structured data format.							
F-03	3.009	The system shall be able to validate diagnosis information to be used in the system.	Examples of validation include: Diagnosis is valid for an associated axis; Diagnosis is active for an associated time period; User authorized to enter diagnosis information; Etc.							

Clinical Data

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-03	3.012	The system shall provide the ability to separately display active problems from inactive/resolved problems.								
F-03	3.013	The system shall support multiple diagnosis standards.	Examples include: DSM IV and ICD-9, ICD-10 diagnoses. Includes any necessary translations of code to code formats.							
F-03	3.016	The system shall be able to manually order a problem list.								

Clinical Data

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-04	4.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print medication lists information.	Examples of medication lists include: Lists based on frequency of medication usage; healthcare service provider medication preferences; etc. Examples of medication list information include: Medication name; dose; route; sig,;dispense amount; refills; associated diagnoses; medication expiration date; medication labeling as ineffective for client, Date of any change made to medication information (including a medication list); Identification of user who made any change to medication information, etc. Implies medication information is stored in discrete data fields and only approved abbreviations shall be used. The medication list shall be "client-centric" and shall include medications prescribed by any provider. Display and printing of information may be controlled through user-selected parameters (e.g., client identifier, date ranges, which information to display, current and/or inactive medication status, brand or generic name of medication, etc.) See Practice Management 43.006 and Infrastructure 43.040							

Clinical Data

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-04	4.002	The system shall be able to indicate that the medication list has been reviewed by both the healthcare service provider and client.	Implies usage of a discrete data record field.							
F-04	4.003	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print all prescribed medication-related information.	Examples of information include: Client prescriptions; Prescribed medications; Non-prescribed medications (e.g.,over the counter and complementary medications such as vitamins, herbs and supplements); Standard medication codes (e.g., NDC number codes); Free text or uncoded medications; Medication name, schedule, quantity, dosage, order date, date last taken, side effects, and effectiveness; Client identifiers; Medication start, end, and renewal dates; Refill quantity; Prescriber identity; Fact that client takes no medications; Reasons for taking, not taking, or discontinuing medication; Source of medication information or history; Date of any change made to medication information (including a medication list); Identification of user who made any change to medication information; Medication contra-indication, Active problem interaction; etc. Implies medication information is stored in discrete data fields and only approved abbreviations shall be used. Copying implies ability to "cut and paste" or otherwise import / export medication information with another data							

Clinical Data

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-04	4.005	The system shall support medication monitoring.	Examples of support include: User-friendly linkage/navigation to Diagnostic Test Order screens; Provider notification when test results are obtained; Etc. Linked to 14.001							
F-04	4.007	The system shall be able to display and print medication history for the client.	Examples of medication history include: Client system identifier and name; medication name, frequency, effective start date and end date, and dosage; Range of dates for history.							
F-04	4.011	The system shall provide the ability to enter non-prescription medications, including over the counter and complementary medications such as vitamins, herbs and supplements.	This is important for interaction checking, associating symptoms with supplements e.g. the L-trytophan related eosinophila-myalgia syndrome							
F-04	4.013	The system shall be able to exclude a medication from the current medication list and document the reason for such action.	Exclusion examples include: medications marked inactive, erroneous, completed, discontinued. Documentation includes identifying the clinical authority authorizing exclusion.							
F-04	4.025	The system shall be able to notify healthcare service providers that client's prescribed medication might be running out.	Implies controlling notifications through business rules; Queries that search for expiring/expired prescriptions; Etc.							

Clinical Data

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-04	4.026	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print medication information in any medication formulary list.	Examples of lists include: Medication formulary for entire organization; Medication formulary defined by client classification, funding, Scope of Practice, Etc. Example of information in lists include: Medication name; Type of list (e.g., agency wide, client classification specific, Etc.); Medication choice prioritization; Medication costs: Etc..							
F-04	4.027	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print medication formulary rules and guidelines.	Examples of rules include: List access; Formulary usage is optional or required criteria; Effective stop / start dates of formulary usage; Etc. Guidelines may be reference documents.							
F-04	4.028	The system shall include access to the National Drug Code (NDC) database.								
F-04	4.029	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print commonly used prescription templates.	Examples of prescription templates include: Templates defined for different healthcare service providers; Etc.							
F-04	4.037	The system shall support client involvement in a Physician Assistance Program (PAP).	Examples of support include: Prompting a healthcare service provider to discuss participation with the client; Providing data fields to record information on client's involvement; Providing reminders when the application renewal is due; Etc. See Practice Management 32.016							

Clinical Data

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-05	5.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print information on medications and other agents to which the client has had an allergic or other adverse reaction.	Examples of information include: Any combination of provider / client defined allergy / adverse reactions lists; Client identifiers; Medication names; Type and severity of allergic or adverse reaction; Reason and authority for action taken on information (i.e., modification, inactivation, Etc.); Date action taken on information; User identifier who took action on information; Source references for information (e.g., Client, relative, friend, healthcare service provider, etc.) "Inactivate" in this context implies specifying that an allergy or allergen specification is no longer valid or active as opposed to deleting the information from the database entirely. The user ID, date & time will be recorded per Security requirements. See Practice Management 43.006 and Infrastructure 43.040							
F-05	5.009	The system shall be able to document review of any allergy or adverse reaction list.	Examples of review documentation include: Reviewer User Identifier; Date stamp of when review option is selected. Medico-legal and regulatory compliance. This requires the user to explicitly select this option documenting that they have reviewed the allergies with the client. Implies documentation will be in a structured format.							

Clinical Data

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-05	5.011	The system shall be able to explicitly indicate that a client has no known drug allergies.	Medico-legal and regulatory compliance. This is meant to be specific to drug allergies. Expected to be available by 2008.							
F-05	5.012	The system shall be able to explicitly indicate that a client has no known non drug allergies.	Expected to be available by 2008.							
F-05	5.015	The system shall be able to check for potential interactions between a current medication and a newly entered allergy.								
F-05	5.016	The system shall interface with third party databases that support automated drug allergy checking to be performed during the medication prescribing process.								
F-05	5.017	The system shall provide the ability to capture non-drug agents to which the client has had an allergic or other adverse reaction.	These could include items such as foods or environmental agents. This need not be accomplished within the same portion of the chart where medication allergies are noted.							

Clinical Data

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-06	6.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print client history information.	Examples of client history include: Services / Treatments; Healthcare service provider identifiers; Medical conditions; Diagnoses; Medical procedures; Immunizations; Date / Times of actions on history data (i.e., additions, modification, inactivation, etc.); Family history; Social history; Hospitalizations; Specific absence of a condition or family history of the condition; Reason and authority for action taken on information (i.e., modification, inactivation, etc.); Date action taken on information; User identifier who took action on information; Source references for information (e.g.,Client, relative, friend, healthcare service provider, etc.); Episodes of care; Prior client or provider alerts, vital signs recordings, client messages, chronic diseases, Post discharge contact information; etc. Episodes of care are based on state and local definitions. Generally, they are by periods of care at a provider, geographical, or organizational level; They may be outpatient or inpatient based and may exist concurrent with other episodes of care.							
F-06	6.002	The system shall capture client history information in a structured data format.								
F-07	7.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print summary list information for each client.	Data may be in a standard and non-standard coded form. Examples of provider documentation include information in: Healthcare service provider assessments, notes, care plans, progress notes, wellness and recovery plans, Etc.							

Clinical Data

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-08	8.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print all healthcare service provider documentation in system. All actions on documentation shall cause a recording of the date / time of the action and the identity of the user who performed the action.	Examples of provider documentation include information in: Healthcare service provider assessments, notes, care plans, progress notes, wellness and recovery plans, Etc. Examples of documentation information include: Client name, Identifier of who entered data, age, gender, problem(s), medical necessity, current and prior healthcare service providers, risk factors, family medical history; Physical health attributes (e.g., client vital signs, blood pressure; temperature; heart rate, respiratory rate, height, and weight, and physical pain levels); Free text notes; Nationally recognized mental/behavioral health care plans and alerts; Language used by client; provider's explanation (and the client understanding) of recommended and/or alternative care plans; Actions taken to safeguard the client to avert the occurrence of morbidity, trauma, infection, or condition deterioration; Problem lists for adults and children; Global Assessment of Functioning (GAF) values; Children Global Assessment Scale (CGAS) scores; Etc. Examples of actions include: input, modify, inactivate, delete, update, display, copy, and print actions. It also includes "finalization" of healthcare service provider sets of documentation as listed above. Input may be by client and provider. (CONTINUED ON NEXT PAGE)							

Clinical Data

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
			Examples of display include: Filtered / sorted by various criteria (e.g., Provider who finalized the note; Diagnosis, Etc.) Conversion of information to numeric values that can be graphed enhances interoperability and for public health surveillance or clinical research.. Examples of numeric coding are found in ICD-9 CM, ICD-10 CM, SNOMED, UMLS, etc., See Practice Management 43.006 and Infrastructure 43.040.							
F-08	**8.003**	The system shall be able to save, and later retrieve, healthcare service provider documentation in progress.	Display of information may include linkages to multiple system database records (e.g., Diagnosis, Allergies, Service / Treatment, etc.)							
F-08	**8.005**	The system shall be able to finalize healthcare service provider documentation, i.e., change the status of the documentation from in progress to complete. Subsequent actions will not destroy any of the original finalized documentation, i.e., strikeouts, addendums, etc., will be used instead of text destruction.								
F-08	**8.007**	The system shall support electronic signatures and co-signatures in documentation.	See Practice Management 43.006 and Infrastructure 43.040							
F-08	**8.008**	The system shall be able to addend to documentation that has been finalized.								

Clinical Data

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-08	8.009	The system shall be able to identify, display and print the full content of a modified documentation.	Implies display and printing of both the original content and the content resulting after any changes, corrections, clarifications, addenda, etc. to a finalized documentation.							
F-08	8.015	The system shall be able to graph client attributes over time.	Examples include: height and weight; Calculated body mass index (BMI); Etc.							
F-08	8.017	The system shall be able to compare body mass index (BMI) to standard norms for age and sex over time.								
F-08	8.018	The system shall be able to indicate to the user when a vital sign measurement falls outside a preset normal range.	Implies that authorized users shall set the normal ranges.							
F-08	8.019	The system shall be able to associate standard codes with discrete data elements in a documentation.	Examples of standard codes include but are not limited to SNOMED-CT, ICD-9 CM, ICD-10 CM, DSM-IV, CPT-4, MEDCIN, and LOINC. This would allow symptoms to be associated with SNOMED terms, labs with LOINC codes, etc. The code associated with a note would remain static even if the code is updated in the future.							
F-08	8.020	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print structured templates for healthcare service provider documentation.	Examples of templates include: Structured progress notes; Intake assessments such as the mini mental health exam; Care Plans; Wellness and Recovery Plans; Etc. User ability to customize templates is preferred. Codified data are data that is structured AND codified according to some 'external' industry accepted standard such as ICD-9 CM, ICD-10 CM, SNOMED-CT, and CPT-4.							

Clinical Data

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-08	8.023	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print comments by the client or the client's representative (henceforth 'client annotations') regarding the accuracy or veracity of information in the client record.	This includes external documentation incorporated in the client records. 2007 it is sufficient for these to be recorded as either free-text notes (see item F59) or scanned paper documents (see item F86). It is not required that the system facilitate direct entry into the system by the client or client's representative.							
F-08	8.024	The system shall display client annotations in a manner which distinguishes them from other content in the system.	Examples of displays include: Use of a different font or text color; A text label on the screen indicating that the comments are from a client or client's representative; Etc. "Distinguishable" refers specifically to comments made by the client or client's representative, but does not refer to the individual components of that chart with which they are in disagreement.							
F-08	8.025	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print client or client proxy completed clinical information.	Once verified by a healthcare service provider and shared with other parts of the chart, the shared data does not need to be identified as client completed in all sections where data may be shared, but the original client completed information shall be maintained.							
F-08	8.027	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print group activity documentation.	Examples of group activity include: Outpatient and Inpatient group therapy sessions; Group therapy sessions funded by multiple funding streams (E.g., Mental Health / Alcohol and Drug); Etc. Implies the ability to handle both documentation common to all participants and documentation distinct to an individual participant.							

Clinical Data

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-08	8.035	The system shall be able to interface with 3rd party products which support documentation.	Examples of products include: Various standard intake assessment instruments; Medical dictionary; Etc.							
F-08	8.044	The system shall provide a location check log that supports the tracking of clients by location.	Examples of client checking include: Client checking on a user-defined basis (e.g. every 5 or 10 minutes). This component is used primarily at inpatient facilities.							
F-08	8.047	The system shall be able to merge client healthcare service provider documentation.	Examples of reasons for merge include: Documentation created under two separate client identifiers but its really for the same client. Does not have to be only duplicate data found in both records.							
F-08	8.048	The system shall be able to display and review all data in two similar type client healthcare service provider documentation records for the same client, identifying the data that is different.	This will support determining the correct client health record information that should exist subsequent to merging two records to one.							
F-08	8.049	The system shall require user confirmation prior to merging any client healthcare service documentation.								
F-08	8.050	The system shall be able to recreate as separate documentation records previously merged client healthcare service provider documentation.								

Clinical Data

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-08	8.064	The system shall support healthcare service provider Report Dictation.	Examples of support include: Voice capture and storage; Routing of voice to transcribers; Integration of audio files with documentation; Usage across various parts of EHR system; Software produced voice to text transcriptions; Usage of nationally recognized best practice dictation software solutions; Etc. Also supported by 8.001 and Infrastructure 43.040							
F-08	8.074	The system shall provide the ability to capture other clinical data elements, such as peak expiratory flow rate, size of lesions, severity of pain, as discrete data								
F-08	8.075	The system shall provide the ability to display other discrete numeric clinical data elements, such as peak expiratory flow rate or pain scores, in tabular and graphical form.	Listed items are examples only.							

Clinical Data

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-09	9.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print external healthcare service provider documentation.	Examples of external documents or their content include: Scanned documents; Electronically submitted documents (e.g., faxes; downloads; etc.); Structured reports (e.g., text-based fields; standard and non-standard codified data, etc.) ; Referral authorizations; Consultant reports; Client correspondence of a clinical nature; External test results (e.g., Labs; X-rays; Physical exams, etc.); Medication detail (e.g., Pharmacy, client, and provider identifiers, medication strength, dosage, Dr. directions; etc.;); Originator of document; Etc. Examples of input documents formats include: Storing as a file of various electronic formats (E.g., .PDF, .Doc, .XLS, .JPG, .TIF, .MPEG, .WAV, .MP3, etc.); Integrating as text or image documents into EHR records / screens; integration through web-links; Etc. Images may include but are not limited to radiographic, digital or graphical images. Examples of document support for EHR system include: Indexing (for retrieval) methodologies; Web-links; Date / Time stamping; Etc. See Practice Management 43.006 and Infrastructure 43							
F-09	9.005	The system shall be able to index documents.	Examples of types of indexing include: Document type; Date of the original document; Date of scanning; Subject and title.							

Clinical Data

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-10	10.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print client instructions and client educational materials.	Examples of client instructions and educational materials include: Medication instructions; Tests and procedures instructions; Vaccine instructions; Care access instructions; Etc.) Implies material would be culturally competent and in county threshold languages. See Infrastructure 43.040 and Practice Management 43.006							
F-10	10.004	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print that client specific instructions or educational material were provided to the client.	Implies material would be culturally competent and in county threshold languages. This does not require automatic documentation.							
F-10	10.010	The system shall be able to link client instructions to other system functions and enable automated printing of instructions.	Examples of system functions include: Management of client care plans, client orders, client scheduling, provider practice guidelines; Etc.							
F-10	10.012	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print a Crisis Management Plan.	Implies that: Plan structure may defined by user; Plan may be prepared by the client and their case manager. Implies integration with other system functions. If a client goes into crisis this plan is easily accessible to provide guidance to staff on the care team and other providers who have contact with the client. See Practice Management 43.006							

Clinical Data

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-10	10.013	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print an Advance Directives Plan.	Examples of advance directives include: Client healthcare service provider preferences; Medication limitations; notifications to relatives or guardians; Etc.; Implies that: Plan structure may defined by user; Plan may be prepared by the client and their case manager. Implies integration with other system functions. If a client goes into crisis this plan is easily accessible to provide guidance to staff on the care team and other providers who have contact with the client. See Practice Management 43.006							

Clinical Data

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-14	14.001	The system shall provide the ability to input, modify, inactivate, delete, update, display, copy, and print results information.	Examples of results information include: Client identifier(s); Linkage to original order information; Test and Result types; Test dates; Result source; Result receipt date; Result type: (E.g., X-ray, lab, vital sign; Etc.); Result status (E.g., normal vs. abnormal status by county definition and/or original data source definition); Effective start/stop date; Result related documentation (E.g., Image documents, Consultation notes, Diabetes education; Etc.;); Client or provider commentary regarding results; alerts identifying a modification to the test or procedure; Etc. Displays may be as numeric or textual data and sorted / filtered by variable criteria (client group identifier, client identifier or multiple client identifiers, test type, test date, normal/abnormal status, etc.); Abnormal data may be highlighted for ease of viewing; See Practice Management 43.006 and Infrastructure 43.040							

Clinical Data

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-14	14.002	The system shall be able to compare results over time.	Examples of result comparisons include: A clients test results to client's own baseline results, organizational baseline results; prior client results, other client results, national standards results, comparisons with prescription and other client data in system; Visual comparison of lab results to prescription information, Etc.; Display may be in numeric flow sheets and/or graphical form. System should indicate if abnormal results are high or low.							
F-14	14.007	The system shall be able to forward a result.	Examples of who may receive the forwarded result include: healthcare service providers; the client; Etc.							

Clinical Data

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-16	16.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print care plan, protocol, and guideline documents.	Examples of guideline documents include: Standard documents; Site-specific documents; Clinical Trial Protocols; Psycho-social assessments, Intake assessments, Addiction Severity Index (ASI), inpatient evaluations, Residential placement evaluations; Etc. Clinical trial protocols may be used to ensure compliance. These documents may reside within the system or be provided through links to external sources. They may be nationally recognized documents. This requirement could be met by simply including links or access to a text document. Road map would require more comprehensive decision support in the future. This includes the use of clinical trial protocols to ensure compliance. See Practice Management 43.006 and Infrastructure 43.040.							
F-17	17.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print the reason for variation from care plans, guidelines, and protocols as discrete data.	See Practice Management 43.006 and Infrastructure 43.040.							

Clinical Data

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-19	19.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print medication administration information.	Example of medication administration information includes: Medication type; Dose; Time of administration; Route; Site; Lot number; Expiration date; manufacturer; Person who administered medication; Data entry user ID. Data shall be stored as discrete data fields. See Practice Management 43.006 and Infrastructure 43.040.							
F-19	19.003	The system shall provide the ability to document immunization administration.								
F-19	19.004	The system shall provide the ability to document, for any immunization, the immunization type, dose, time of administration, route, site, lot number, expiration date, manufacturer, and user ID as structured documentation.								
F-19	19.005	The system shall provide the ability to record an adverse reaction to a specific immunization.	Immunization allergies may be indicated in the Allergy section.							
F-19	19.006	The system shall provide the ability to alert a user at the time of ordering that the client had a prior adverse reaction to that immunization.								

Clinical Data

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-21	21.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print information on criteria guidelines for disease management, preventive services, and wellness alerts.	Examples of criteria information include: Client demographic data (minimally age and gender); Clinical data (e.g., problem list, current medications, Etc.); Implies that guidelines are interfaced with organization's business rules. The criteria guidelines may: Be internal or external based; Use clinical trial protocols to ensure compliance; Cause automatic and proactive alerts (e.g., contact care provider without physician intervention); Come from national organizations, medical societies, etc. See Practice Management 43.006, 43.009, 43.010 and Infrastructure 43.040.							
F-21	21.002	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print alerts based on established guidelines.	Guidelines may be from national organizations, payers, or internal protocols. See Practice Management 43.012							
F-21	21.006	The system shall be able to override guideline alerts.	Includes all or part of the alerts.							
F-21	21.007	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print reasons alerts were overridden.	Needed for medico-legal reasons and clinical decision support.							

Clinical Data

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-21	21.009	The system shall trigger clinical alerts that present urgent clinical information.	Examples of urgent clinical information include: Danger warnings, suicide watch or similar, drug allergies, history of adverse reactions to specific drugs, and other urgent precautions. Examples of alerts types include: Clinical alerts for incarcerated clients (e.g., suicide watch, drug dealing, and protective custody Alerts to be viewed at various key screens including those that handle progress notes, appointments and service/Care Plans. See Practice Management 43.009, 43.010, and 43.012.							
F-21	21.022	The system shall provide the ability to document that a preventive or disease management service has been performed based on activities documented in the record (e.g., vitals signs taken).								
F-21	21.023	The system shall provide the ability to document that a disease management or preventive service has been performed with associated dates or other relevant details recorded.	This could include services performed internally or external to the practice.							

Clinical Data

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-21	21.024	The system shall provide the ability to document that a disease management or preventive service has been performed with associated dates or other relevant details recorded.	This is done at the client level. Examples include but are not limited to: *Remove mammography for woman that has had a mastectomy *Remove annual pap smear alert for a woman who has had a complete hysterectomy. *Inactivate an alert for routine colon cancer screening in a client who is terminally ill.							
F-22	22.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print criteria information for disease management, preventative services, and wellness notifications and reminders.	Examples of criteria information include: Client demographic data (minimally age and gender); Clinical data (e.g., problem list, current medications, Etc.) Implies guidelines are interfaced with organization's business rules. The criteria guidelines may: Be internal or external based; Use clinical trial protocols to ensure compliance; Cause automatic and proactive notifications and reminders (e.g., contact client without physician intervention); Come from national organizations, medical societies, etc. See Practice Management 43.006, 43.009, 43.010 and Infrastructure 43.040.							
F-22	22.002	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print notifications and reminders based on established guidelines.	Guidelines may be from national organizations, payers, or internal protocols. See Practice Management 43.012							

Clinical Data

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-22	22.004	The system shall trigger clinical notifications and reminders.	Examples of clinical notifications and reminders include: One or more clients are due or overdue for disease management, preventive, or wellness service / treatments; See Practice Management 43.009, 43.010, 43.012, and Infrastructure 43.040.							
F-22	22.007	The system shall be able to override guideline notifications and reminders.	Includes all or part of the notifications and reminders.							
F-22	22.009	The system shall provide the ability to display reminders for disease management, preventive, and wellness services in the client record.	It is expected that in the future discrete data elements from other areas of the chart will populate matching fields.							
F-22	22.010	The system shall provide the ability to identify criteria for disease management, preventive, and wellness services based on client demographic data (age, gender).								
F-29	29.001	The system shall be able to define one or more reports as the formal Health Record for disclosure purposes.	This allows the practice to not print demographics, certain confidential sections, or other items. Report format may be plain text initially. In the future there will be a need for structured reports as interoperability standards evolve.							
F-29	29.002	The system shall be able to generate hardcopy or electronic output of part or all of the individual client's Health Record.	This could include but is not limited to the ability to generate standardized reports needed for work, school, or athletic participation.							
F-29	29.003	The system shall be able to generate Health Record hardcopy and electronic output by date and/or date range.								

Clinical Data

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-29	29.004	The system shall be able to export structured data which removes those identifiers listed in the HIPAA definition of a limited dataset. This export on hardcopy and electronic output leaves the actual PHI data unmodified in the original record.	De-identifying data on hardcopy or electronic output is necessary for research. However, it is emphasized that this function is not intended to cleanse the text in the note or data in the original record. As per HIPAA Standards for Privacy of Individually Identifiable Health Information, 45 CFR Parts 160 and 164, identifiers that shall be removed are: 1. Names; 2. Postal address information, other than town or city, state and zip code; 3. Telephone numbers; 4. Fax numbers; 5. Electronic mail addresses; 6. Social security numbers; 7. Health record numbers; 8. Health plan beneficiary numbers; 9. Account numbers; 10. Certificate/license numbers; 11. Vehicle identifiers and serial numbers, including license plate numbers; 12. Device identifiers and serial numbers; 13. Web Universal Resource Locators (URLs); 14. Internet Protocol (IP) address numbers; 15. Biometric identifiers, including finger and voice prints; and 16. Full face photographic images and any comparable images.							
F-29	29.006	The system shall have the ability to provide support for disclosure management in compliance with HIPAA and applicable law.	This criterion may be satisfied by providing the ability to create a note in the client's record. More advanced functionality may be market differentiators or requirements in later years.							

Clinical Data

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-30	30.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print all client service / treatment information.	Examples of service / treatment information include: Information entry by keyboard; Structured data entry utilizing templates, forms, pick lists or macro substitution; Dictation with subsequent transcription of voice to text, either manually or via voice recognition system. See Infrastructure: 43.040.							
F-30	30.003	The system shall be able to associate individual service / treatments with diagnoses.								
F-30	30.004	The system shall have the ability to provide filtered displays of service / treatments.	Examples of filtered displays include: Display by date of service; healthcare service provider; associated diagnosis; Etc.							
F-34	34.001	The system shall be able to update the clinical content or rules utilized to generate clinical decision support notifications, reminders and alerts.	Growth charts, CPT-4 codes, drug interactions would be an example. Any method of updating would be acceptable. Content could be third party or customer created.							
F-34	34.002	The system shall be able to update clinical decision support guidelines and associated reference material.	Any method of updating would be acceptable. Content could be third party or customer created.							
I-04	4.001	The system shall be able to send a report of client immunizations to an immunization registry	State immunization registries are not using uniform national standards at this time. The CVX and MVX vocabularies constitute an option for representing immunizations, but have not been addressed by HITSP at this time. Working Group will evaluate standards and options for future versions of HL7.							

CA Department of Mental Health
BH-EHR Requirements Survey
Clinical Data Management Requirements

Clinical Data

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
I-04	4.002	The system shall be able to retrieve immunization registry information and import immunization record information into the EHR	State immunization registries are not using uniform national standards at this time. The CVX and MVX vocabularies constitute an option for representing immunizations, but have not been addressed by HITSP at this time. Working Group will evaluate standards and options for future versions of HL7.							
Clinical Data Totals:			**Number of Requirements**	**0**	**0**	**0**	**0**	**0**	**0**	
			98	**Existing**	**Planned**	**Modification**	**Custom**	**3rd Party**	**Not Addressed**	

CA Department of Mental Health
BH-EHR Requirements Survey
Computerized Provider Order Entry (CPOE) Requirements

Computerized Provider Order Entry(CPOE)

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-04	4.009	The system shall be able to input, modify, inactivate, delete, update, display, and print medication history received electronically.	Medication history examples include: Medication prescription history.							
F-11	11.001	The system shall be able to input, modify, inactivate, delete, update, display, and print information for prescription or other medication orders which meet State Board of Pharmacy requirements for correct filling and administration by a pharmacy.	Implies an ordering sub-system with all necessary data to complete an order, and other functionality such as pending orders, etc. The term pharmacy here refers to all entities which fill prescriptions and dispense medications including but not limited to retail pharmacies, specialty, and mail order pharmacies. See Clinical 4.003 and Practice Management 4.006.							
F-11	11.002	The system shall be able to record user and date stamp for prescription related events.	Examples of prescription related events include: Initial creation, renewal, refills, discontinuation, and cancellation of a prescription.							

CA Department of Mental Health
BH-EHR Requirements Survey
Computerized Provider Order Entry (CPOE) Requirements

Computerized Provider Order Entry(CPOE)

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-11	11.004	The system shall allow authorized individuals to sign and cosign medication orders.	The words, "sign," "signature," "cosign," and "co signature" are intended here to convey actions, rather than referring to digital signature standards. It is recognized that an electronic signature is useful here. However, a widely accepted standard for electronic signatures does not exist. Thus, the criterion calls for documenting the actions of authenticated users at a minimum. In the future, when appropriate digital signature standards are available, certification criteria shall be introduced using such standards.							
F-11	11.007	The system shall be able to maintain a coded list of medications and correlate the medications to NDC numbers.	For clarification - Coding means a unique identifier for each medication.							
F-11	11.009	The system shall be able to check for daily dose outside of recommended range for client age (e.g., off-label dosing).	Year to be determined once e-prescribing sig requirements have been defined.							
F-11	11.010	The system shall be able to check for dose ranges based on client age and weight.								
F-11	11.011	The system shall be able to select a drug by therapeutic class.	As available through 3rd-party drug databases.							

CA Department of Mental Health
BH-EHR Requirements Survey
Computerized Provider Order Entry (CPOE) Requirements

Computerized Provider Order Entry(CPOE)

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-11	11.012	The system shall be able to electronically verify client prescription eligibility and receive, display, store and update information received accordingly.	Will be required by e-prescribing. This criterion shall maintain a record of whether the client was eligible for coverage in the system.							
F-11	11.013	The system shall be able to input, modify, inactivate, delete, update, display, and print information received through review of health plan/payer formulary.	If this review included medications already on the medication list, a duplicate record in the medication shall not be created (same date, medication, strength, and prescriber). Formulary checking refers to whether a particular drug is covered.-							
F-11	11.014	The system shall be able to reorder a prior prescription without re-entering previous data (e.g. administration schedule, quantity).								
F-11	11.015	The system shall be able to print and electronically fax prescriptions.	Appropriate audits and security shall be in place.							
F-11	11.016	The system shall be able to re-print and re-fax prescriptions.	This allows a prescription that did not come out of the printer, or a fax that did not go through, to be resent/reprinted without entering another prescription. Appropriate audits and security shall be in place.							

CA Department of Mental Health
BH-EHR Requirements Survey
Computerized Provider Order Entry (CPOE) Requirements

Computerized Provider Order Entry(CPOE)

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-11	11.017	The system shall be able to send prescriptions electronically, including ability to document source of prescription order (e.g., "phone in" orders).	Prescription information includes: Structured and coded Sig. instructions. This implies: Pharmacy is capable of receiving electronic prescriptions (e-prescribing and not faxing); There is formulary compliance capability (e.g., RXHub); System is able to receive prescription update information from pharmacy (e.g., prescription filled); Etc.							
F-11	11.018	The system shall be able to display a dose calculator for client-specific dosing based on weight and age.	This allows the user to enter pertinent information to calculate doses. This would be an interim step until databases are available to calculate doses automatically.							
F-11	11.019	The system shall be able to display client specific dosing recommendations based on age and weight.	This would calculate automatically from pertinent information in the chart (age and weight) and shall be in standard units and based on a standard periodicity. This is contingent upon availability of databases. We encourage their rapid development.							
F-11	11.020	The system shall be able to display client specific dosing recommendations based on renal function.	On roadmap for 2010							
F-11	11.021	The system shall have the ability to receive and display information about the client's financial responsibility for the prescription.	This could include co-payments or tier level of the drug obtained through an interface with a pharmacy benefits manager (PBM).							

CA Department of Mental Health
BH-EHR Requirements Survey
Computerized Provider Order Entry (CPOE) Requirements

Computerized Provider Order Entry(CPOE)

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-11	11.022	The system shall be able to identify any medication dispensed (including samples), documenting lot number and expiration date.	Lot numbers and expiration date could be entered in free text or encoded.							
F-11	11.023	The system shall be able to prescribe fractional amounts of medication (e.g. 1/2 tsp, 1/2 tablet).	Very important to prescribing for pediatric and geriatric clients.							
F-11	11.024	The system shall be able to prescribe non-NDC coded medications.								
F-11	11.028	System shall be able to allow the user to configure prescriptions to incorporate fixed text according to the user's specifications and to customize the printed output of the prescription.	This refers to the "written" output and language on the prescription such as specific language, dispense as written. For instance, users shall be able to modify the format/content of printed prescriptions to comply with state Board of Pharmacy requirements.							
F-11	11.029	The system shall be able to associate a diagnosis with a prescription.								
F-11	11.030	The system shall be able to display the associated problem or diagnosis (indication) on the printed prescription.	At least one diagnosis shall be able to be displayed but the ability to display more than one is desirable. Associated problem or diagnosis can be non-structured data or structured data.							

CA Department of Mental Health
BH-EHR Requirements Survey
Computerized Provider Order Entry (CPOE) Requirements

Computerized Provider Order Entry(CPOE)

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-11	11.031	The system shall provide links to general prescribing information at the point of prescribing.	Example: Physician Desk Reference (PDR)							
F-11	11.032	The system shall be able to create user-defined specific medication lists of the most commonly prescribed drugs with a default dose, frequency, and quantity.	"User-defined" refers to medical staff and support staff that utilizes the lists.							
F-11	11.033	The system shall be able to add reminders for necessary follow up tests based on medication prescribed.	This does not imply that this shall be an automated process.							

CA Department of Mental Health
BH-EHR Requirements Survey
Computerized Provider Order Entry (CPOE) Requirements

Computerized Provider Order Entry(CPOE)

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-12	12.001	The system shall be able to input, modify, inactivate, delete, update, display, and print order information for diagnostic tests, including labs and imaging studies.	Examples of orders information include: Client identifiers; Ordering provider; Order type (e.g., diagnostic test, lab work, imaging studies, etc.); One or more associated problems or diagnoses; Order status (e.g., complete, incomplete, etc.); Etc. Implies an ordering sub-system with all necessary data to complete an order, and other functionality such as pending orders, etc. It is desirable that all information for medical necessity checking be captured. This includes physicians and authorized non-physicians. See Practice Management 43.006.							
F-12	12.002	The system shall be able to associate a problem or diagnosis with the order.	May associate more than one problem or diagnosis with the order.							

CA Department of Mental Health
BH-EHR Requirements Survey
Computerized Provider Order Entry (CPOE) Requirements

Computerized Provider Order Entry(CPOE)

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-12	12.004	The system shall be able to capture applicable signatures and co-signatures for all test orders.	The words, "sign," "signature," "cosign," and "cosignature" are intended here to convey actions, rather than referring to digital signature standards. It is recognized that an electronic signature is useful here. However, a widely accepted standard for electronic signatures does not exist. Thus, the criterion calls for documenting the actions of authenticated users at a minimum. In the future, when appropriate digital signature standards are available, certification criteria shall be introduced using such standards.							
F-12	12.006	The system shall be able to display user created instructions and/or prompts when ordering diagnostic tests or procedures.	Refers to diagnostic test or procedure specific instructions and/or prompts; not client specific instructions and/or prompts. Instructions and/or prompts may be created by the system administrator. A 3rd party product may be used, providing that the instructions and/or prompts appear at the point of care.							
F-12	12.007	The system shall be able to transmit orders for a diagnostic test to the correct internal or external destination for completion.	Mechanisms for relaying orders may include providing a view of the order, sending it electronically, or printing a copy of the order or order requisition.							
F-12	12.009	The system shall be able to display or print orders by like or comparable type, e.g., all radiology or all lab orders.	May include filters or sorts.							

CA Department of Mental Health
BH-EHR Requirements Survey
Computerized Provider Order Entry (CPOE) Requirements

Computerized Provider Order Entry(CPOE)

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-12	12.012	The system shall be able to validate lab work order information.	Examples of validation include: Medical Necessity exists; Test order compliant with business rules; Etc.							
F-13	13.001	The system shall be able to input, modify, inactivate, delete, update, display, and print a set of related orders to be subsequently ordered as a group on multiple occasions.	Examples of order sets include: Medications; Laboratory tests; Imaging studies; Procedures; Referrals; Etc. Does not imply that the system needs the ability to create an order set on the fly.							
F-13	13.004	The system shall be able to display orders placed through an order set either individually or as a group.	Need to be able to see the individual components of the order set, rather than just the name of the order set. Does not mean to break down a lab panel into individual components.							
F-13	13.005	The system shall allow individual items in an order set to be selected or deselected.								
F-14	14.004	The system shall be able to notify the relevant providers (ordering, copy to) that new results have been received electronically.	Examples of notifying the provider include but are not limited to a reference to the new result in a provider "to do" list or inbox.							
F-14	14.011	The system shall allow user acknowledgment of a result presentation.	This is separate from audit trail.							

CA Department of Mental Health
BH-EHR Requirements Survey
Computerized Provider Order Entry (CPOE) Requirements

Computerized Provider Order Entry(CPOE)

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-14	14.020	The system shall be able to input, modify, inactivate, delete, update, display, and print clinical results received through an interface with an external source.	Implies meeting standards for client confidentiality (e.g., HIPAA) and electronic transfer protocols (e.g., HL7 based). In addition to lab and radiology reports, this might include interfaces with case/disease management programs and others. See Clinical 14.001and 14.003							
F-14	14.021	The system shall be able to input, modify, inactivate, delete, update, display, and print discrete lab results received through an electronic interface.	Implies meeting standards for client confidentiality (e.g., HIPAA) and electronic transfer protocols (e.g., HL7 based). This may be an external source such as a commercial lab or through an interface with on site lab equipment. See Clinical 14.001and 14.003							

CA Department of Mental Health
BH-EHR Requirements Survey
Computerized Provider Order Entry (CPOE) Requirements

Computerized Provider Order Entry(CPOE)

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-18	18.001	The system shall be able to trigger drug interaction alerts.	Examples of alert reasons include: Known potential Interactions between medications to be prescribed and (current medications, allergies, client's condition as indicated by test results, past ineffectiveness of medication for client, certain types of diseases, client problem documentation, etc.); Potential interactions with current medication when new client documentation entered (e.g., client problem; client dietary information); Age (This could be based on user defined medication lists or on standard lists such as the Beers lists.); As a precautionary alert that drug interaction, allergy, and formulary checking will not be performed against the uncoded or free text medication; Drug information is outdated; Etc. Implies timely alerts to users, healthcare service providers, clients; Etc. Drug interaction alerts may be due to automated third party software database references; Alerts may be prioritized in system. Alerts reduces risk of inappropriate prescribing, prevents pharmacy call backs, and can reduce malpractice liability.							

CA Department of Mental Health
BH-EHR Requirements Survey
Computerized Provider Order Entry (CPOE) Requirements

Computerized Provider Order Entry(CPOE)

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-18	18.003	The system shall be able to prescribe a medication despite alerts for interactions and/or allergies being present.	See Clinical 21.006, 22.007, Practice Management 43.009, 43.010, and 43.012.							
F-18	18.004	The system shall be able to input, modify, inactivate, delete, update, display, and print the severity level at which drug interaction warnings shall be displayed.								
F-18	18.006	The system shall be able to require documentation of at least one reason for overriding any drug-drug or drug-allergy interaction warning triggered at the time of medication ordering.	Necessary for medico-legal purposes. See Clinical 21.006, 22.007, Practice Management 43.009, 43.010, and 43.012.							
F-18	18.007	The system shall trigger proactive alerts, for clients on a given medication when they are due for required laboratory or other diagnostic studies, to monitor for therapeutic or adverse effects of the medication.	Limited to availability of databases. See Practice Management 43.009, 43.010, and 43.012.							
F-18	18.010	The system shall display, on demand, potential interactions on a client's medication list, even if a medication is not being prescribed at the time.								

CA Department of Mental Health
BH-EHR Requirements Survey
Computerized Provider Order Entry (CPOE) Requirements

Computerized Provider Order Entry(CPOE)

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-18	18.013	The system shall be able to input, modify, inactivate, delete, update, display, and print the rationale for triggering a drug interaction alert.	Drug reference information typically provided by drug database vendors is an example of the source to obtain the rationale. See Clinical 21.001, 22.001, Practice Management 43.009, 43.010, and 43.012.							
F-18	18.016	The system shall support accessibility of drug specific education materials from third party databases.								
F-18	18.019	The system shall be able to update drug interaction databases.	This includes updating or replacing the database with a current version.							
F-18	18.022	The system shall provide the ability to check for potential interactions between a current medication and a newly entered allergy.								
F-25	25.001	The system shall be able to input, modify, inactivate, delete, update, display, print, transmit and receive electronic information between prescribers and pharmacies or other intended recipients of the medication order.	Examples of electronic information include: Initial medication order; Medication order renewals; Renewal requests and Notification of prior authorizations from or on behalf of any dispensing entity; Medication order cancellations; Etc. Until electronic standards are established, FAX is a suitable means of transmission.							
I-02	2.004	The system shall be able to order radiology tests.								

CA Department of Mental Health
BH-EHR Requirements Survey
Computerized Provider Order Entry (CPOE) Requirements

Computerized Provider Order Entry(CPOE)

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
I-02	2.005	The system shall be able to order and schedule radiology tests.								
CPOE Totals:			Number of Requirements	0	0	0	0	0	0	
			54	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	

Electronic Health Record (EHR)

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-06	6.005	The system shall provide the ability to capture history collected from external sources.	Episodes of care are based on state and local definitions. Generally, they are by periods of care at a provider, geographical, or organizational level; They may be outpatient or inpatient based and may exist concurrent with other episodes of care.							
F-24	24.015	The system shall be able to interchange electronic clinical information between healthcare service provider systems.	Examples of sources for clinical information includes: Client registration, episodes, admissions, discharges, authorization, and service / treatments information. Implies that interchange of data will be compliant with standards (HL 7, etc.). Implies both internal and external providers.							
I-01	1.001	The system shall be able to receive general laboratory results (includes ability to replace preliminary results with final results and the ability to process a corrected result)	Implies compliance with HL7 and LOINC standards.							
I-01	1.002	The system shall be able to receive microbiology laboratory results	Organisms will be coded using SNOMED, Sensitivity testing will be coded using LOINC							
I-01	1.003	The system shall be able to respond to a query to share laboratory results	Part of ONC EHR-Lab Use Case Will work with Ambulatory Functionality Work Group to align functionality criteria and interoperability roadmap dates in preparation for next round of public comments.							

CA Department of Mental Health
BH-EHR Requirements Survey
Electronic Health Record (EHR) Requirements

Electronic Health Record (EHR)

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
I-01	1.004	The system shall be able to send an order for a laboratory test	Further work is need on defining the ordering messages and codes for ordering tests, should include an EHR generated order number for tracking							
I-01	1.005	The system shall be able to send a query to check status of a test order	Part of a function for closing the orders loop as part of quality improvement. Also need to be able to detect orders not matched with results.							
I-02	2.001	The system shall be able to receive imaging reports and view images, includes ECG and other images as well as radiology								
I-02	2.002	The system shall be able to send a query to other providers to share imaging results	See also line CCHIT IA 5.6 send a query to a registry for documents							
I-02	2.003	The system shall be able to respond to a query to share imaging results with other providers								
I-03	3.002	The system shall be able to electronically acknowledge a request for a refill sent from a pharmacy	Transaction is now wide spread use so that systems that send new prescriptions need to be ready to respond to requests for refills.							
I-03	3.003	The system shall send be able to a cancel prescription message to a pharmacy	Sent by the prescriber to cancel a prescription that was sent previously							
I-03	3.004	The system shall be able to respond to a request for a prescription change from a pharmacy	Sent by the pharmacy to request that the prescriber make changes to a prescription before it is filled.							

CA Department of Mental Health
BH-EHR Requirements Survey
Electronic Health Record (EHR) Requirements

Electronic Health Record (EHR)

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
I-03	3.006	The system shall be able to send a query to verify prescription drug insurance eligibility and coverage	An essential first step prior to sending a query for medication history or formulary information directed at prescription drug coverage.							
I-03	3.007	The system shall be able to access and view formulary information from pharmacy or PBM	Usually preceded by a query for insurance eligibility to verify potential source of data.							
I-03	3.008	The system shall be able to send a query for medication history to PBM or pharmacy to access and view medication list from EHR	Part of ONC CE-PHR Use Case, used effectively during Medicare Part D pilots.							
I-05	5.001	The system shall be able to register documents with document registry	The ability to register documents in a registry or a repository will be part of the NHIN and final architecture has not been selected.							
I-05	5.002	The system shall be able to send a query to a document registry for documents.	This criterion is for the query request. This function deals only with the document registry and repository and the references to specific documents have been removed. When the criteria are finalized, any document constraints that are required by the network standards will be identified.							
I-05	5.003	The system shall be able to send documents to repository	This criterion is for sending documents to the repository. The function of sending documents to a repository may be independent of the specific types of documents that will be identified by the network standards. Use of HITSP harmonized standards is expected and it is too early to set those standards at this time.							

Electronic Health Record (EHR)

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
I-05	5.004	The system shall be able to respond to a query to provide a document that was previously registered in a repository	This function refers only to the ability to provide a document that has been registered in response to a query. The ability to create documents and medical summaries are discussed in other lines below.							
I-05	5.005	The system shall be able to create and send electronic documentation of a visit such as a consult letter to a referring physicians	Will include narrative data							
I-05	5.007	The system shall be able to send Medical Summary to refer or transfer clinical care of client	Used for structured data. Use of CCR will require available translation to CCD.							
I-05	5.008	The system shall be able to receive Medical Summary and import into EHR for consult or transfer of clinical care	May use direct communication or a regional network							
I-05	5.009	The system shall be able to send data to PHR	Use of CCR will require available translation to CCD, Use of XPHR is for interim use per HITSP IS-03							
I-05	5.010	The system shall be able to securely receive data from PHR and import into EHR	Use of CCR will require available translation to CCD, Use of XPHR is for interim use per HITSP IS-03							
I-06	6.002	The system shall be able to import home physiologic monitoring data from clients.	Part of AHIC Chronic Care Breakthrough, standards and implementation guides have not been selected yet							

Electronic Health Record (EHR)

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
I-07	7.001	The system shall be able to send client specific Public Health Disease Report for a reportable disease.	Electronic replacement for traditional reportable disease notifications to health departments, may become part of bio-surveillance in the future.							
I-07	7.002	The system shall be able to send anonymous utilization and laboratory bio-surveillance data to public health agencies.	ONC Bio-surveillance Use Case							
I-07	7.008	The system shall support administrative communication with registry services.	Examples of administrative communication include: Usage of registry interface and communication standards; Client identification; Retrievals of healthcare information links; payer, health plan, and client sponsor information; Employer identification; Public Health Agency identification; Healthcare resources identification; Coding, Terminology model, and Terminology verification and updates; Exchange of client data; Version control; Etc. See Practice Management 43.021.							

CA Department of Mental Health
BH-EHR Requirements Survey
Electronic Health Record (EHR) Requirements

Electronic Health Record (EHR)

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
I-07	7.015	The system shall support standard terminologies for administrative and financial communications.	Areas of standard terminology may include: Internal and external communications; Administrative or Financial coding; Usage of explicit information models; Cross walking or deprecating different versions of standards; Updating standards information or standards protocols; Utilizing standards appropriate to effective start / end dates; Cascading terminology based on coded terminology content in clinical models (e.g., templates, and custom formularies); Terminology mapping; Standards validation; Realm specific and local profile communication; User Scope of Practice communications; Organizational Policy or law enforcement; Etc.							
I-08	8.002	The system shall be able to send a query to coordinate client identification	Client identification coordination will be part of network certification scheduled to begin in 2009 and is required as part of the document transport criteria.							
I-08	8.003	The system shall be able to support standard interfaces to Practice Management and Billing systems.	CCHIT requires more input on stakeholder priorities and feasibility of certifying a standard interface between all EHR systems and all practice management systems and billing systems							
I-08	8.007	The system shall be able to receive electronic authorization for referral from payer.	The system shall be able to receive electronic authorization for referral from payer.							

CA Department of Mental Health
BH-EHR Requirements Survey
Electronic Health Record (EHR) Requirements

Electronic Health Record (EHR)

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
I-09	9.001	The system shall be able to respond to a query to Identify clients eligible for a clinical trial.	Clinical trial will send eligibility criteria, EHR will identify clients for review by practice and respond with a count of potentially eligible clients and an intent to participate or not participate in the trial.							
I-09	9.002	The system shall be able to send data to register a client in a clinical trial.	Will include informed consent							
I-09	9.003	The system shall be able to receive clinical trial protocol and templates for data collection.	Will include clinical trial protocol and data collection templates							
I-09	9.004	The system shall be able to send a data report to a clinical trial.	Will require digital signature to assure authentication, integrity, and non-repudiation.							
EHR Totals:			***Number of Requirements***	***0***	***0***	***0***	***0***	***0***	***0***	
			37	***Existing***	***Planned***	***Modification***	***Custom***	***3rd Party***	***Not Addressed***	

CA Department of Mental Health
BH-EHR Requirements Survey
Personal Health Record (PHR) Requirements

Personal Health Record (PHR)

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
F-06	6.014	The system shall be able to input, modify, inactivate, delete, update, display, and print information from a personal health record (PHR).								
F-15	15.010	The system shall provide access control supporting Client authorization to import or export PHR data.	It is implied that the client (or their authorized representative) is "in control" of the client's PHR data . This includes related PHR data imports and export.							
I-03	3.011	The system shall be able to respond to a query for medication history sent by a PHR.	Part of ONC CE-PHR Use Case, may use PHR standards such as HL7/CCD and ASTM CCR instead of NCPDP standards, final standards to be specified by HITSP.							
I-04	4.003	Import immunization history from a PHR.	May be part of ONC Use Cases for 2007, represents an alternative to obtaining this data from State immunization registries.							
I-05	5.006	The system shall be able to send information to a client for review via a personal health record (PHR).	See Practice Management 43.012.							
I-05	5.008	The system shall support client usage of a PHR.	Examples of support include: Providing the client a secured PHR website; Providing clients a portal to a PHR website; Etc.							

CA Department of Mental Health
BH-EHR Requirements Survey
Personal Health Record (PHR) Requirements

Personal Health Record (PHR)

Req. Ctgy.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
I-05	5.011	The system shall be able to receive registration summary from client and import into EHR.	Use of CCR will require available translation to CCD, Use of XPHR is for interim use per HITSP IS-03							
PHR Totals:			Number of Requirements	0	0	0	0	0	0	
			7	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	

CA Department of Mental Health
BH-EHR Requirements Survey
Response Summary

Company Name:									
Product Name:									
DMH Roadmap Category	*Nbr of Reqs.*	*Met by Existing Functionality*	*Within 12 Months*	*Requires Software Modifications*	*Requires Custom Development*	*Requires Third Party*	*Not Addressed*	*No Response*	*Invalid Response*
Infrastructure	96	0	0	0	0	0	0	96	0
		0%	0%	0%	0%	0%	0%	100%	0%
Practice Mgmt	162	0	0	0	0	0	0	162	0
		0%	0%	0%	0%	0%	0%	100%	0%
Clinical Data	98	0	0	0	0	0	0	98	0
		0%	0%	0%	0%	0%	0%	100%	0%
CPOE	54	0	0	0	0	0	0	54	0
		0%	0%	0%	0%	0%	0%	100%	0%
EHR	37	0	0	0	0	0	0	37	0
		0%	0%	0%	0%	0%	0%	100%	0%
PHR	7	0	0	0	0	0	0	7	0
		0%	0%	0%	0%	0%	0%	100%	0%
Total	454	0	0	0	0	0	0	454	0
		0%	0%	0%	0%	0%	0%	100%	0%

CA Department of Mental Health
Behavioral Health EHR Requirements Survey
Requirement Category Descriptions

Category Number	Category Name	Category Description
Functional Requirements		
F01	***Identify and maintain a client record***	Key identifying information is stored and linked to the client record. Both static and dynamic data elements will be maintained. A look up function uses this information to uniquely identify the client.
F02	***Manage client demographics***	Contact information including addresses and phone numbers, as well as key demographic information such as date of birth, gender, and other information is stored and maintained for reporting purposes and for the provision of care.
F03	***Manage Problems list***	Create and maintain client problems list(s).
F04	***Manage medication list***	Create and maintain client specific medication lists- Please see DC.1.7.1 for medication ordering as there is some overlap.
F05	***Manage allergy and adverse reaction list***	Create and maintain client specific allergy and adverse reaction lists.
F06	***Manage client history***	Capture, review, and manage services/treatment, hospitalization information, other information pertinent to clients care.
F07	***Summarize health record***	
F08	***Manage clinical documents and notes***	Create, correct, authenticate, and close, as needed, transcribed or directly entered clinical documentation.
F09	***Capture external clinical documents***	Incorporate clinical documentation from external sources.
F10	***Generate and record client specific instructions***	Generate and record client specific instructions as clinically indicated.
F11	***Order medication***	Create prescriptions or other medication orders with detail adequate for correct filling and administration.
F12	***Order diagnostic tests***	Submit diagnostic test orders based on input from specific care providers.
F13	***Manage order sets***	Provide order sets based on provider input or system prompt, medication suggestions, drug recall updates.
F14	***Manage results***	Route, manage, and present current and historical test results to appropriate clinical personnel for review, with the ability to filter and compare results.
F15	***Manage consents and authorizations***	Create, maintain, and verify client treatment decisions in the form of consents and authorizations when required.
F15a	***Manage patient advance directives***	Capture, maintain, and provide access to patient advance directives.

CA Department of Mental Health
Behavioral Health EHR Requirements Survey
Requirement Category Descriptions

Category Number	Category Name	Category Description
F16	***Support for standard care plans, guidelines, protocols***	Support the use of appropriate standard care plans, guidelines, and/or protocols for the management of specific conditions.
F17	***Capture variances from standard care plans, guidelines, protocols***	Identify variances from client-specific and standard care plans, guidelines, and protocols.
F18	***Support for drug interaction***	Identify drug interaction warnings at the point of medication ordering
F19	***Support for medication or immunization administration or supply***	To reduce medication errors at the time of administration of a medication, the client is positively identified; checks on the drug, the dose, the route and the time are facilitated. Documentation is a by- product of this checking; administration details and additional client information, such as injection site, vital signs, and pain assessments, are captured. In addition, access to online drug monograph information allows providers to check details about a drug and enhances client education.
F20	***Support for non-medication ordering***	Referrals, care management
F21	***Present alerts for disease management, preventive services and wellness***	At the point of clinical decision making, identify client specific suggestions / reminders, screening tests / exams, and other preventive services in support of disease management, routine preventive and wellness client care standards.
F22	***Notifications and reminders for disease management, preventive services and wellness***	Between healthcare service/treatments, notify the client and/or appropriate provider of those preventive services, tests, or behavioral actions that are due or overdue.
F23	***Clinical task assignment and routing***	Assignment, delegation and/or transmission of tasks to the appropriate parties.
F24	***Inter-provider communication***	Support secure electronic communication (inbound and outbound) between providers in the same practice to trigger or respond to pertinent actions in the care process (including referral), document non-electronic communication (such as phone calls, correspondence or other service/treatments) and generate paper message artifacts where appropriate.
F25	***Pharmacy communication***	Provide features to enable secure and reliable communication of information electronically between practitioners and pharmacies or between practitioner and intended recipient of pharmacy orders.
F26	***Provider demographics***	Provide a current directory of practitioners that, in addition to demographic information, contains data needed to determine levels of access required by the EHR security and to support the delivery of mental health services.

CA Department of Mental Health
Behavioral Health EHR Requirements Survey
Requirement Category Descriptions

Category Number	Category Name	Category Description
F27	***Scheduling***	Support interactions with other systems, applications, and modules to provide the necessary data to a scheduling system for optimal efficiency in the scheduling of client care, for either the client or a resource/device.
F28	***Report Generation***	Provide report generation features for the generation of standard and ad hoc reports
F29	***Health record output***	Allow users to define the records and/or reports that are considered the formal health record for disclosure purposes, and provide a mechanism for both chronological and specified record element output.
F30	***Service/treatment management***	Manage and document the health care delivered during an service/treatment.
F31	***Rules-driven financial and administrative coding assistance***	Provide financial and administrative coding assistance based on the structured data available in the service/treatment documentation.
F32	***Eligibility verification and determination of coverage***	Includes the verification of Medi-Cal eligibility, the ability to process retroactive health plan eligibility, the ability to handle HIPAA-compliant Eligibility Determination, Enrollment and Disenrollment electronic data formats, and the ability to generate medication-specific "Patient Assistance Programs (PAP)" applications forms to request medications at no cost from manufacturers.
F33	***Manage Practitioner/Patient relationships***	Identify relationships among providers treating a single client, and provide the ability to manage client lists assigned to a particular provider.
F34	***Clinical decision support system guidelines updates***	Receive and validate formatted inbound communications to facilitate updating of clinical decision support system guidelines and associated reference material
F35	***Enforcement of confidentiality***	Enforce the applicable jurisdiction's client privacy rules as they apply to various parts of an EHR-S through the implementation of security mechanisms.
F36	***Data retention, availability, and destruction***	Retain, ensure availability, and destroy health record information according to organizational standards. This includes: Retaining all EHR-S data and clinical documents for the time period designated by policy or legal requirement; Retaining inbound documents as originally received (unaltered); Ensuring availability of information for the legally prescribed period of time; and Providing the ability to destroy EHR data/records in a systematic way according to policy and after the legally prescribed retention period.
F37	***Audit trails***	Provide audit trail capabilities for resource access and usage indicating the author, the modification (where pertinent), and the date and time at which a record was created, modified, viewed, extracted, or removed. Audit trails extend to information exchange and to audit of consent status management (to support DC.1.5.1) and to entity authentication attempts. Audit functionality includes the ability to generate audit reports and to interactively view change history for individual health records or for an EHR-system.

CA Department of Mental Health
Behavioral Health EHR Requirements Survey
Requirement Category Descriptions

Category Number	Category Name	Category Description
F38	***Extraction of health record information***	Manage data extraction in accordance with analysis and reporting requirements. The extracted data may require use of more than one application and it may be pre-processed (for example, by being de-identified) before transmission. Data extractions may be used to exchange data and provide reports for primary and ancillary purposes.
F39	***Concurrent Use***	EHR system supports multiple concurrent physicians through application, OS and database.
F40	***Mandated Reporting***	Manage data extraction accordance with mandating requirements.
F41	***Administrative A/P EHR Support***	Accounts Payable functions.
F42	***Administrative A/R EHR Support***	Accounts Receivable functions.
F43	***Administrative Workflows EHR Support***	Example Workflow Areas Include: Quality management functions; Client, customer or provider satisfaction surveys; Complaint and compliment forms, Referral functions; and user-definable screen configurations or data fields, etc.

CA Department of Mental Health
Behavioral Health EHR Requirements Survey
Requirement Category Descriptions

Category Number	Category Name	Category Description
Interoperability Requirements		
I01	**Laboratory**	Includes the ability to query about and receive general laboratory results, the ability to replace preliminary results with final results and the ability to process a corrected result.
I02	**Imaging**	Includes the ability to order and receive imaging reports and view images, including ECG and other images as well as radiology.
I03	**Medications**	Includes the ability to order, modify or cancel prescriptions and to exchange medication information with pharmacies and with a client's Personal Health Record (PHR).
I04	**Immunizations**	Includes the ability to exchange information with an immunization registry and with a client's Personal Health Record (PHR)
I05	**Clinical Documentation**	Includes the ability to exchange clinical information with other providers, document registries, other EHR systems and a client's Personal Health Record (PHR).
I06	**Chronic Disease Management/ Patient Documentation**	Includes the ability to import home physiologic monitoring data from clients.
I07	**Secondary Uses of Clinical Data**	Includes the ability to send client specific Public Health Disease Report for a reportable disease, send anonymous utilization and laboratory bio-surveillance data to public health agencies and interface with registry services.
I08	**Administrative & Financial Data**	Includes the ability to send a query to coordinate client identification, support standard interfaces to Practice Management and Billing systems, and receive electronic authorization for referral from payer.
I09	**Clinical Trials**	Includes the ability to identify clients and support participation in clinical trials.

CA Department of Mental Health
Behavioral Health EHR Requirements Survey
Requirement Category Descriptions

Category Number	Category Name	Category Description
Security Requirements		
S01	**Security: Access Control**	Examples include: Assigning access by User identity, User role, User work assignment, Group work assignments, Client's health condition, and Work Context such as time of day or user/client location(s) etc.
S02	**Security: Authentication**	Includes the assigning of passwords and protecting against inappropriate authentication attempts by: Locking the account / node until released by a System Administrator, locking the account / node for a configurable time period, or delaying the next login prompt according to a flexible delay algorithm.
S03	**Security: Documentation**	Refers to the documentation available to the customer that provides guidelines for configuration and use of the EHR System security controls necessary to support secure and reliable operation of the system.
S04	**Security: Technical Services**	Services and standards such as encryption using triple-DES (3DES) or the Advanced Encryption Standard (AES) and an open protocol such as TLS, SSL, IPSec, XML encryptions, or S/MIME or their successors necessary to insure the confidentiality of all Protected Health Information (PHI) delivered over the Internet and/or other known open networks.
S05	**Security: Audit Trails**	Examples of audit trails include: Versions of installed software, code sets, knowledge bases, backup and recovery resolutions, system date / time changes, archived data storage or restoration, and user EHR System access (internal or external).
S06	**Reliability: Backup/Recovery**	The ability to restore functionality to a fully operational and secure state including the restoration of the application data, security credentials, and log/audit files to their previous state.
S07	**Reliability: Documentation**	Includes documentation for: system installation, known security issues/conflicts, the necessary physical environment, network services/protocols, and the minimal privileges necessary for each service and protocol necessary to provide EHR functionality and / or serviceability.
S08	**Reliability: Technical Services**	Includes the certification that software is free of malevolent software (“malware”), support for key system Performance Metrics and integration with an uninterruptible power supply (UPS).